

**DESCRIPTION AND EVALUATION
OF ARTS THERAPIES PRACTICE WITH ADULTS
SUFFERING FROM DEPRESSION IN THE UK**

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Art builds up self-knowledge, and is an excellent way of communicating the resulting fruit to other people. Getting others to share our experiences is notoriously difficult; words can feel clumsy. Consider trying to describe a walk alongside a lake on a mild afternoon without the aid of an image.

Alain de Botton
(Art as Therapy)

Abstract

This thesis contributes new knowledge to the field of arts therapies and their relevance in the treatment of depression in adults.

The global burden of depression means that available treatments do not address all areas within the complexity of the condition and arts therapies may potentially present a relevant alternative by offering opportunities for non-verbal expression and exploration of creativity. Literature up to date does not offer comprehensive enough description of arts therapies practice and therefore establishing of credible evidence has not been possible. This thesis addresses the gap by exploring the nature of arts therapies practice and its value in the treatment of depression.

The research consists of two phases: phase 1 provides a description of arts therapies practice with depression in the UK based on data collected from 395 survey respondents, while phase 2 evaluates group brief art therapy for adults experiencing mild to moderate depression. The project employs mixed methodologies within a creative research design incorporating surveys, interviews, arts-based inquiry and a pilot clinical study to examine multiple perspectives and offer findings meaningful to diverse audience.

This project establishes that depression is a common condition among arts therapists' clients while some of the practitioners consider work with depression their main area of professional interest. It further finds that the therapists address depression through the use of humanistic, psychodynamic and integrative approaches and discovers that certain areas of the therapy process have particular relevance in the treatment of depression (e.g. time, group work, motivation, reconnecting).

The pilot clinical study concludes with decrease of depression levels and increase of subjectively perceived wellbeing in all participants immediately after nine sessions of art therapy and in the follow-up. Participants' experiences, researcher's observations and arts-based reflections on the therapy process highlight the potential value of arts therapies in areas relating to, among others: connection and sharing, awareness of others and self, sense of achievement, self-expression and regain of meaning. The findings are integrated in the final discussion, which proposes a set of concepts particularly relevant to the treatment of adult depression through arts therapies.

This research provides the first comprehensive description of arts therapists' work with depression in the UK and confirms the potential of this practice to be effective, which is relevant to health professionals and may lead to increased involvement of arts therapies in mainstream healthcare. The particular value of this project lies in shaping the basis for further explorations in the form of larger RCTs as well as demonstrating relevance and superiority of creative research designs in evaluating arts therapies.

Keywords

depression, arts therapies, psychotherapy, music therapy, dance movement psychotherapy, art therapy, dramatherapy, mixed methodology, survey, pilot study, assessment of feasibility

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1. Introduction

This thesis is about arts. It is also about psychotherapy. Most importantly, it is about depression. It was inspired by a belief in a purposeful union of these.

More specifically, this thesis is a result and an account of a three year long journey in search of an understanding of how arts therapists in the UK address depression in their practice and what value their work may present in the treatment of this condition. Although modest in its scope, this work offers both a description and evaluation of practice and in its essence is a pilot study, which would hopefully be followed by further research.

The background of this project lies in the acknowledgement of the significance of the increasing problem of depression in modern world and in the UK in particular. It also has its roots in the researcher's interest in arts and psychotherapy and their combined potential in the treatment of mental health conditions.

Inspiration for this project originated largely from the researcher's work within various mental health settings in Scotland, where the use of arts in therapy and recovery process appeared to have benefited adults experiencing a spectrum of mental health problems, of which depression seemed to have been the most common diagnosis. Observation that adults affected by other mental health conditions often revealed symptoms of depression led to realisation that addressing depression could potentially have an impact on a widely understood mental ill-health. Further observations of how the condition is approached through the commonly available treatments and how the sufferers respond to these suggested that there were areas within the complexity of depression which remained unaddressed. Acclaimed treatments appeared to lack tools to meaningfully explore the loss of creativity or difficulties with verbal expression of emotions. It seemed likely that including arts in therapy might offer benefits to adults suffering from depression.

In her work throughout the years leading to this project the researcher had numerous and invaluable opportunities to witness how engagement in art making seemed to have

had positive impact on the wellbeing of many of her clients, patients and service users affected by depression. Having later personally facilitated art therapeutic workshops and groups within the community and mental health hospital settings, the researcher had a chance to observe that adults with depression often responded to therapeutic interventions well and valued their input in their recovery process. It was also significant that therapeutic relationship with the facilitator often seemed to have strengthened the positive impact of creativity itself, which could have only been natural to the researcher, who trained in psychotherapy and valued the potential of therapeutic process. Although inspirational, these informal observations could not offer any further understanding of mechanisms and impact of art making within the therapy space on depression specifically. The realm of arts therapies, as disciplines successfully combining appreciation for arts in human wellbeing with psychotherapy principles, seemed the most appropriate field to explore in search of a deepened understanding.

At the time when this project started (in 2010), little was known about how (and whether) arts therapists work with depression. However, it was becoming increasingly obvious that the prevalence of the condition had been on the rise and the widely acclaimed treatment options did not seem to offer solutions suitable for all depression sufferers. Numerous accounts from arts therapists seemed to confirm that they often worked with the condition and anecdotal evidence was available. It was, however, fragmented and did not offer enough credibility for arts therapies to become commonly acknowledged treatment options. In an evidence focused world, it became crucial to assess whether arts therapies were effective in alleviating symptoms of depression. Evaluation of arts therapies for this condition seems vital and could potentially improve the quality of treatment, expanding currently available options. However, no such evaluation may be possible until the intervention is precisely known and specified and it soon became apparent that what constitutes arts therapies practice with depression remained unknown. Whether there were particular ways in which arts therapists worked with the condition had not been captured with enough scientific credibility before the start of this project. While it seemed likely that arts therapists encounter and address depression in their practice, their interventions were expected to have been influenced by various sources of clinical knowledge, experience, possibly intuition and not a specific guideline. Evaluation of arts therapies for depression became, thus, impossible without an understanding of what constitutes this practice.

The need for definition and more transparency in how depression is tackled in arts therapies was apparent and recognition that only the practitioners themselves may offer sufficient insight later led to conducting of a nationwide survey. It was hoped that once a description of arts therapies practice is possible, an evaluation of this practice could follow. An attempt was made to develop a treatment manual for an arts therapies intervention to be used in this project. It seemed vital to provide even a modest scale evaluation which would offer a chance to observe in practice how the process of arts therapies is actually used to address depression. The idea eventually led to conducting of a pilot study, in which group art therapy was offered to adults affected by depression and evaluated from various perspectives, including quantitative data and accounts from the participants, the therapist and the researcher.

Consequently, this work presents a description of how arts therapists work with depression and an evaluation of a brief group art therapy offered to adults affected by the condition.

It needs to be mentioned at this very beginning that this research follows a methodologically complex design and employs mixed methodologies with sequential and concurrent data collection procedures and qualitative as well as quantitative components. Development of a creative research design, incorporating a variety of perspectives, seemed essential for a comprehensive evaluation enriched with a deeper understanding of the therapy process. It was also important to offer findings meaningful to a diverse audience, including arts therapists, other health professionals and, most importantly, adults suffering from depression. Assuming that this aim was achieved, the project might most appropriately be considered an inter-disciplinary research, in which concepts relevant to the fields of healthcare, arts and general human wellbeing are explored.

The scope of this research was never to be broad enough to allow for an assessment of evidence in an RCT, but it was acknowledged that a pilot project would allow for a larger research to follow and would equip any further studies with experience needed to avoid major flaws in a relatively young field of study. While arts therapies research is rapidly developing, it still lacks credible backgrounds to draw upon and the work presented here should not be seen as a complete chapter but rather as an introduction to more in-depth research on arts therapies for depression. It is a nature of pilot projects to be

incomplete and imperfect and the work presented here is no different. In fact, it possibly consists of more small research disasters than successes. They will all be commented on as honestly as is possible and it is hoped that any discrepancies in the process of this project will add to, enrich and eventually improve the general experience of research in arts therapies.

Structure of this thesis

This thesis consists of six chapters, the content of which will now be briefly described.

Chapter 1 (Introduction) has provided an overview of the whole research, the scientific and clinical rationale behind it and researcher's personal motivation to undertake this project.

Chapter 2 (Literature review) aims to provide a comprehensive background of the fields of arts therapies and depression. Initially, a brief introduction to the connections between the condition in question (depression) and the proposed treatment (arts therapies) is offered, exploring the role of arts and creativity in depression and picturing the established position of arts in mental health.

Secondly, the concepts of depression and arts therapies are looked at more closely and a number of definitions are provided. Individual and social implications, as well as available treatment options for depression are explored. Arts therapies are then defined and presented as a possibly valuable treatment option.

The third section of literature review strengthens the relationship between arts therapies and depression by presenting current research in the field, including both qualitative and quantitative studies. Up to date studies are discussed against their clinical value as well as ability to inform evidence based practice. Initially, a general attitude towards research within the field of arts therapies is explored. Secondly, the state of current knowledge on whether and how arts therapists work with depression is

discussed. Aspects of clinical practice are explored and related to available literature. Eventually, evaluation of arts therapies for depression based on available literature is presented, its value for the development of arts therapies' professions and for clinical practice is discussed and selected areas for improvement are indicated.

Finally, the purpose of this research is positioned in relation to current knowledge, while the need for comprehensive description and evaluation of arts therapies practice with depression is identified.

Chapter 3 (Methodology) discusses methodological aspects of the presented research. Firstly, philosophical foundations of the study and their relevance to the field are presented and followed by verbal explanation and visual illustration of the research design which employs mixed methodologies. Relationship between the two phases of this research is explored and the roles of qualitative and quantitative methods and connections between them are explained. Justification of the study design is then offered, its complex nature is discussed against trends in arts therapies research and potential to represent value for different audiences is indicated.

Methodological details of the two phases of this research are then presented following the same structure. Detailed descriptions of the purpose, procedure, participants, methods, data analysis, ethical considerations and trustworthiness are offered separately for each of the two research phases. The two core aims of this project emerge: 1) to describe arts therapies practice with depression, 2) to evaluate this practice (on example of group art therapy for adults suffering from mild to moderate depression). Additional aim to assess feasibility of a larger study is also explained in more details.

Connections leading towards methodological integration of the two phases are once again highlighted and complete the chapter.

Chapter 4 (Findings and initial discussion) offers a detailed presentation of results obtained through analysis of multimodal datasets in the two phases of this research. For increased transparency, findings originating from quantitative and qualitative analyses are initially presented separately, to eventually be integrated in further sections.

Elements of discussion often accompany individual results, especially where the points raised are specific to particular finding and help explain findings that follow.

In the first section of the chapter quantitative results from phase 1 of this research (Arts Therapies Survey) are presented and discussed to be followed by qualitative findings, based on analysis of arts therapists' responses to open-ended items in two surveys. Both types of findings are finally merged and discussed. It is then explained how the described findings inform the development of intervention in phase 2 and the connection between the two phases of the research is achieved.

Second part of the chapter offers the result of analyses of multiple datasets from phase 2 (pilot study of a single group, pre, post and follow-up test design). Initially, qualitative findings from interviews with participants are presented and followed by more qualitative findings from participant observation and arts-based reflection. The presentation is completed by quantitative results based on participants' scores in three questionnaires in three points in time. Finally, an integration of the findings is offered.

Third section of the chapter presents findings concerning assessment of feasibility of a larger study. Various aspects of feasibility are discussed including assessment of recruitment potential, resources, acceptability of intervention and increase of clinical expertise with the intervention. Eventually, recommendations for future studies of a larger scale are offered.

Chapter 4 (Core discussion) aims to draw on the previously presented findings to extract the essence of this methodologically complex project. While it seemed important to integrate the findings and results from both phases of this research, key concepts emerging from the project are identified and discussed against individual findings and relevant literature.

Chapter 5 (Conclusions) presents a brief summary of the content of this thesis and its finding, offers final reflections from the researcher and makes recommendations for future research projects.

2. Literature review

2.1 Introduction

This chapter aims to provide a comprehensive background of the fields of arts therapies and depression, by initially introducing the role of arts and creativity in mental wellbeing, exploring the nature of depression, picturing the established position of arts therapies in mental health and finally offering a review of relevant research literature.

Firstly, the concepts of depression and arts therapies are brought onto the scene, their definitions provided and characteristics relevant to this project indicated. The structure leads from general to more specific ideas and thus, theoretical constructs are initially presented in isolation, before meaningful connections and relationships are explored. Individual and social implications, as well as available treatment options for depression are explored and the field of arts therapies is introduced, including explanation of formal regulations and indication of common aspects of practice. Eventually initial connections are made between the condition (depression) and a possibly valuable treatment option (arts therapies).

The final section of literature review strengthens the relationship between arts therapies and depression much further and presents current knowledge in the field and recent research developments. An attitude towards research within the field of arts therapies is initially discussed. Available research in the field is then presented, including both qualitative and quantitative studies. Their value for the development of arts therapies' professions and for clinical practice is discussed and selected areas for improvement are identified.

Finally, the scope of the current study is indicated in relation to the knowledge already available and it is explained how the research aims to address gaps recognised in literature.

2.1.1 Arts in mental health

The relationship between arts and wellbeing has been constantly developing from the very beginnings of human existence. Recognition that both admiration and active engagement in arts offer multiple benefits to mental health is commonly accepted. The emotional impact which works of art have on their audience may be observed in music halls, art galleries and theatres. While emotions evoked by appreciation of arts may often hold multiple qualities, not necessarily immediately positive, it is acknowledged that arts have an immense power to induce an experience of catharsis – a release of unwanted emotions necessary to achieve inner balance. An ability to involve emotions “in a raw and uncensored manner” (Warren 2008: 43) is considered a potential of arts to address mental health problems.

Participation in the creative process offers artists a chance to develop self-knowledge and connections to other people and experiences. While mental ill-health often has its roots in inability to express emotions or create opportunities for meaningful connections with aspects of self and outside world, arts provide a link to diverse experiences and help us discover areas within human existence not necessarily available to mind or thought. Arts enrich our perception of the world and increase opportunities for finding meanings. McNiff (1981: 28) explains: “If art cannot physically eliminate the struggles of our lives, it can give significance and new meaning and a sense of active participation in the life process.” Artists often comment on how their engagement in the creative process helps them uncover aspects of self and existence, which would otherwise remain unavailable to their consciousness. Pure joy which may be found in art making is also often mentioned as is satisfaction coming from the process.

Connections between arts and mental health have now exceeded anecdotal evidence and potential of arts to facilitate improvement of mental wellbeing has been acknowledged by many (Heenan 2006; Spandler et al. 2007). In the UK potential benefits of arts in general health have been widely explored (Staricoff 2004; Daykin et al. 2008) and include conclusions on mental health in particular, suggesting that both active and passive participation in arts have positive effects on emotional wellbeing. Critical voices should also be acknowledged (e.g. Hamilton et al. 2003), as they indicate the need for further research in the field – a theme not to be ignored in the light of recommended evidence-based practice.

McNiff (1981: 152) associates the first links of arts and psychiatry with the development of psychoanalysis and “the correlation of visual imagery with dream experiences and the generally accepted belief that pictures will provide tangible evidence as to the nature of the person’s inner conflict.” Recognition of the healing potential of arts led to the development of arts therapies as disciplines relatively recently. However, the relationship between arts and therapy is far more ancient and seems to have dual meaning, while some argue that not only arts may be seen as therapy but therapy may, or possibly should, be considered art: “Acknowledging therapy as an ‘art’ reinforces acceptance of art into the therapeutic structure and facilitates the integration/blending of art and psychotherapy.” (Coleman & Farris-Dufrene 1996: 15). Nevertheless, connection between the two concepts is strong and increasingly more often recognized in the context of mental health. McNiff (1981: 38) vividly explains: “When art and psychotherapy are joined, the scope and depth of each can be expanded, and when working together, they are tied to the continuities of humanity’s history of healing.”

2.2 Presentation of the main concepts

2.2.1 Depression

According to WHO depression is “a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration” (WHO 2010). The effects of this condition are damaging to the person as a whole and involve body, affect, behavior and cognitive processes or, in other words, “mood, physical, mental and behavioural experiences” (Hammen & Watkins 2007: 3) A non-academic but evocative summary of this impact can be found online from Depression Guide (2010): “It affects the way a person eats and sleeps, the way one feels about oneself, and the way one thinks about things.” While some of the symptoms of depression are considered normal human experiences if they occur for a reason, i.e. in response to negative events (Walsh 2009), they may indicate an illness if they last for longer than two weeks (Royal College of Psychiatrists 2010).

While there is no simple definition, as depression is a broad and heterogenous disorder (NICE guideline 90, 2009) with “different etiological and clinical features” (Hammen & Watkins 2007: 36) or a “multifactorial illness with biological, social and psychological factors” (SIGN guideline 114, 2010), a variety of types are recognized. Depending on the origin of depression, there used to be a popular distinction between endogenous depression, believed to be inherited, where no particular cause could be identified and reactive depression, being a mind’s response to a traumatic event or reaction to the severity of life stresses. While the second usually results in successful and lasting treatment, endogenous depression is more likely to be a recurrent condition, often lasting for a lifetime with fairly calm periods of remission followed by depressive episodes.

Currently other types of depression are more likely to be spoken about: primary depression, which is not a result of any other medical or psychological cause and secondary depression, caused by a medical condition or psychiatric illness. Primary depression is often referred to as a major depression, unipolar depression or clinical depression (Walsh 2009).

Multiple theories of depression have been developed over the years, each highlighting one or several of its aspects, but usually failing to provide holistic perspective. For instance, cognitive issues in depression have been addressed by the cognitive-behavioural model, its genesis has been explained by the psychodynamic theorists (Abraham 2011), while its physical presentation is often tackled with prescribed exercise. However, for its complexity, it may be most useful to approach depression from a holistic perspective, using “a comprehensive biopsychosocial model, whereby different factors are examined and different fields are represented” (O’Donohue & Graybar 2009: 324).

While research on causes of depression remains inconclusive, it is “most likely caused by a combination of genetic, biological, environmental, and psychological factors” (NIMH 2013). The compromising biopsychosocial approach accepts the complexity of depression and acknowledges that its causes cannot be simplified to singular origins. Major life events and changes (not necessarily negative), upbringing environment, availability of social support, thinking patterns and many other factors contribute to the onset of depression and its following presentation.

2.2.1.1 Individual and social implications

Regardless of its etiology, depression is “enormously impairing” (Hammen & Watkins 2007: 3) and not only seriously affects individuals’ and their families’ wellbeing, but is also a ‘global burden’ (Scott and Dickey 2003). By the year 2020 depression is predicted to become the second most disabling illness in the world after ischaemic heart disease (WHO 2010). In England alone it is predicted that the number of people with depression would rise by 17% between 2006 and 2026 (NICE Costing statement 2009).

At its worst, depression can lead to suicide with up to 80% of all suicides committed by sufferers of major depression and around 1 in 6 adults diagnosed with depression eventually commit suicide (CSAG 2000). It is estimated that 20% of people in Scotland will experience depression at some point in their lives (DAScot 2011) while some data suggest that even one third of all individuals are likely to experience episode of depression during their lifetime (Rorsman et al. 1990).

Apart from devastating effect to the individuals and communities in its social aspect, depression has huge financial implications. Total annual cost of this illness (including lost employment) is estimated at £7.5 billion in England alone (McCrone 2007) and predicted to reach £12.2 billion by 2026 (NICE Costing statement 2009).

2.2.1.2 Co-morbidity of depression

Although some groups of people are more prone to develop depression, the condition can affect anybody, regardless of age, nationality, background or lifestyle (Walsh 2009). Due to its complexity and severity ranging from very mild to profoundly disabling, depression may be best understood as a spectrum rather than category. While depression may affect individuals in a single episode, it is common for the condition to become recurrent (Hammen & Watkins 2007).

Possibly the most challenging feature of depression is its high co-morbidity with other conditions (Kessler et al. 2005), both physical and mental health related. Anxiety is the most common co-morbidity, present in approximately 60% of depression sufferers (Hammen & Watkins 2007).

Other co-morbidities include long term, disabling or life-threatening physical conditions (e.g. heart disease, cancer, diabetes, chronic pain) and related problems within mental health spectrum (e.g. trauma, dementia, learning difficulties, eating disorders). Simms et al. (2012: 15) notice that patients often present to primary care settings with “a complex mixture of anxiety, depression and somatic symptoms”, which places challenges on health care professionals, expected to make vital decisions not only on diagnosis but more importantly on treatment choices.

As its recent mental health strategy highlights, the Scottish Government is committed to respond to the significance of co-morbidity of depression with other long term and disabling conditions and identifies addressing depression as a priority (The Scottish Government 2012: 37).

2.2.1.3 Diagnosis

Diagnosis of depression in the UK should be made by a trained health professional and is most commonly based on guidelines included in the ICD-10 Classification of Mental and Behavioural Disorders (WHO 1997), which are used in the National Health System. According to ICD-10, diagnosis of depression may be made when at least one of the three core symptoms (persistent sadness or low mood, loss of interests or pleasure, fatigue or low energy) is present for most of the time over two weeks. Other symptoms complete the list (disturbed sleep, poor concentration or indecisiveness, low self-confidence, poor or increased appetite, suicidal thoughts or acts, agitation or slowing of movements, guilt or self-blame) and their number determines severity of depression.

Another classification and diagnostic guidelines are provided in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) developed by the American Psychiatric Association, where depression is referred to as a Major Depressive Disorder (MDD). Considering the particularly medical orientation of DSM-5 and controversy around the classification (NHS Choices 2013), it is becoming less popular among practitioners supporting the more complex biopsychosocial model of depression.

2.2.1.4 Treatment options

Due to its complexity in both etiology and presentation, a range of very different attempts to treat depression have been developed. While the need for holistic approach to treatment is being postulated more often, this proves to be challenging in case of the condition, which affects individuals in many different ways: mentally, emotionally and physically. Therefore, treatments are rarely aimed to target all symptoms and usually tackle specific area/s of sufferers' wellbeing, such as cognition or affect. Generally, best known solutions include pharmacological treatment and psychotherapy. It is also highlighted that a supportive personal environment and social support often intensify the healing process (Detweiler-Bedell et al. 2013; Ibarra-Rovillard & Kuiper 2011). Despite controversies, electroconvulsive therapy (ECT) is still offered to patients, for whom other treatments were not effective (Walsh 2009).

In the UK, there are several treatment options available and provided by NHS Trusts, which include antidepressant medication, psychosocial and psychological interventions. National evidence based guidelines for healthcare interventions, developed by the National Institute for Health and Care Excellence (NICE) in England and Wales and the Scottish Intercollegiate Guidelines Network (SIGN) in Scotland, include more and less clear recommendations for treatments of depression.

NICE guideline 90 (2009) recommends a combination of antidepressant medication and either CBT (cognitive behavioural therapy) or IPT (interpersonal therapy) in the treatment of moderate and severe depression. Both options may present disadvantages. Antidepressants and other medication may cause serious side effects and the results are usually satisfactory for as long as the person is medicated, not offering long lasting effects, therefore not presenting a cure but only relieving symptoms of depression. It has also been noted that sufferers of chronic depression tend to respond better to psychotherapy than medication (Anderson 2011). The risk-benefit ratio of antidepressants in the treatment of persistent depressive symptoms and mild depression is poor (NICE clinical guideline 90 2009). Talking therapies are usually more effective long term but are costly and not suitable for all groups of clients (e.g. disadvantaging people who experience problems with verbal communication). In clinical practice in the UK, a combination of psychotherapy and medication (Friedman 2011) is

often considered the most effective and universal treatment and is commonly offered to people suffering from depression.

It is argued (Middleton et al. 2005) that while NICE guidelines for severe to moderate depression are fairly clear, appropriate treatment recommendations for mild to moderate depression are of poorer quality and less obvious. The contrast between the quality of evidence for different levels of severity of depression seems to highlight the need for more research on treatment options suitable for milder forms of the condition.

Counselling and some forms of psychotherapy are commonly considered treatments for mild and moderate depression. Among the most popular are brief cognitive, behavioural and interpersonal therapies (Lambert & Davis 2007).

Cognitive behavioural therapy (CBT) is a well evidenced treatment, often offered to patients of the NHS in combination with medication (Sudak 2011). In a very brief summary, CBT focuses on altering unhelpful thinking patterns and understanding negative emotions, responding to cognitive aspects of depression. CBT may be offered in several modes: individual therapy, group therapy, guided self-help (Walsh 2009) and, recently increasingly popular, online therapy (Living Life to the Full, Williams 2013). Interpersonal Psychotherapy for depression (ITP, Klerman et al. 1994) was developed to address relational and social contexts in depression and is now an acclaimed treatment option. Very recently, ITP has been used as a model for a new form of therapy, Dynamic Interpersonal Therapy (DIT, Lemma et al. 2011). Inspired by psychodynamic and group analytic theory, DIT not only responds to issues around relationships outside of therapy, but also postulates the advantages of therapeutic relationship and dynamic processes happening in the therapy room.

Referring back to the biopsychosocial model of depression, nowadays the need for holistic approach towards this condition is often stressed (Llewellyn-Jones & Donnelly 2000) and a comprehensive treatment plan within interdisciplinary clinical teams is usually seen as the best way to achieve improvement in many aspects of life, affected by depression, by incorporating "a broad spectrum of ideas, plans, and interventions in order to remain most helpful to a wide range of depressed clients." (O'Donohue & Graybar 2009: 324-325).

2.2.2 Arts therapies

‘Arts therapies’ is a generic term used to refer to four different disciplines in the UK, that is: art therapy or art psychotherapy (AT), music therapy (MT), dramatherapy (DT) and dance movement psychotherapy (DMP). They differ in preference for an artistic medium as a therapy’s tool but all share a core belief that arts have a healing potential and trained therapist can use them intentionally (Cattanach 1999) in therapeutic interventions.

All four arts therapies “focus on non-verbal communication and creative processes together with the facilitation of a trusting, safe environment within which people can acknowledge and express strong emotions” (Payne 1996: xi) and therefore differ significantly from therapeutic arts or artistic activities. Similarly to other forms of psychotherapy, the therapeutic process and a well-defined relationship (Karkou and Sanderson 2006: 46) between the therapist and the client enable the positive change to happen. By considering non-verbal communication in the therapeutic process, arts therapies offer valuable alternative to medication and talking therapies.

The British Association of Art Therapists claims that arts therapies are “(...) committed to understanding and utilising the therapeutic potentials of both psychological therapy approaches and the art form employed” (BAAT 2010) and stresses the importance of dual training for all arts therapists. The same arguments have been put forward by the other three arts therapies professional associations. In consequence, arts therapists in the UK train at a postgraduate level in at least two years Masters programmes held in Higher Education establishments. A degree of maturity and relevant work experience are essential requirements for entering psychotherapeutic training. While sharing common interest and skills in using arts in treatment, all arts therapies remain independent professions with separate training programmes and separate professional associations (Quality Assurance Agency for Higher Education 2004).

2.2.2.1 One or many disciplines?

Extensive similarities and significant differences mean that arts therapies might be best regarded both as one field and as several separate disciplines. Only such broad perspective allows for a true understanding of a nature of these professions.

As one field, “arts therapies are the creative use of the artistic media as vehicles for non-verbal and/or symbolic communication, within a holding environment, encouraged by a well-defined clients-therapist relationship, in order to achieve personal and/or social therapeutic goals appropriate for the individual.” (Karkou and Sanderson 2006: 46) As separate professions, arts therapies not only use different arts media, but also adopt different preferred therapeutic approaches and traditions, tend to work with different client groups and vary in their engagement in research.

Some therapists especially value the similarities and the common philosophical and therapeutic background of arts therapies. The importance of seeing the field of arts therapies “as a whole” was postulated in a vivid metaphor by McNiff, who claims that “by separating the parts of the body from one another, we lose their combined strength” (McNiff 1981:27). Recently, the notion can be observed among arts therapists to both acknowledge the common roots and highlight the specifics, on which their professional identity relies. The leaders of different arts therapies programmes in the UK often work in collaboration to promote exchange of knowledge and experience. Conferences and additional professional training events are commonly attended by therapists from all disciplines and are sometimes enhanced by the presence of professionals from other related areas, including psychologists and psychiatrists. However, the degree to which these contacts are encouraged depend on individual arts therapies settings, with some promoting multidisciplinary work more strongly than others.

It needs to be noted that, although the current study aims to explore arts therapies practice in the UK specifically, other countries have their own classifications of arts therapies, often significantly different to the British model (Karkou et al. 2011). For instance, other arts therapies disciplines which use different forms of artistic expression, like poetry or creative writing, have been recognized worldwide. Also, in some countries a more integrative approach to arts therapies is common and in the US they are often referred to as Creative Arts Therapies (Chisolm 2007: 398), a term which includes the therapies recognized in the UK, as well as poetry therapy and psychodrama. Alternative term of “expressive arts therapy” (Knill et al. 2005) is also common. On occasions, several means of artistic expression are combined in a single therapy intervention and such approach is commonly referred to as “integrative arts therapy”.

2.2.2.2 Arts therapies in relation to psychotherapy and therapeutic arts

As indicated at the beginning of this section, arts therapies are different to arts activities or therapeutic arts and, although they have the use of arts and creativity in common, it is important to highlight the unique qualities of arts therapies as opposed to active or passive participation in arts. By the author of this work arts therapies are considered to be a very specific form of psychotherapy. Similar notion is recognized among many practitioners, especially from art and dance movement therapies, who tend to refer to their practices as arts psychotherapies. Such tendency is less common among music and dramatherapists.

Regardless of the name, all arts therapies share certain principles fundamental in the very generally understood field of psychotherapy. One of these, which clearly differentiates arts therapies from arts activities, is the central position of a therapeutic relationship in the therapy process. Engagement in arts or experimenting with creativity is thus undertaken in the presence of a therapist, whose role is complex and includes the facilitation of a safe healing environment, in which therapeutic relationship between the therapist and the client may be developed as a safe container for often difficult psychological explorations.

Another difference from a simple engagement in arts is related to an intention with which therapy is undertaken and an essential element of arts therapies involves “the intentional use of the arts for psychological change” (Karkou & Sanderson 2006: 31). It needs to be noted that while the sole contact with arts is often therapeutic, the healing potential of arts therapies is never accidental. An intention to heal (Cattanach 1999: 7) and purposeful targeting of areas in which change would improve client’s wellbeing form the very fundaments of arts and other psychotherapies.

The third feature differentiating arts therapies from arts activities is an attitude towards what and how is produced in the effect of the creative engagement. While there is a common acknowledgement of the value of an artistic outcome in therapy, it is not considered essential for the successful therapy and the process of creation itself is recognized as equally or possibly more valuable (Karkou & Sanderson 2006). It is believed that the sole engagement in the process offers the healing potential and any outcomes offer an added value. However, there is no opposition in the outcome and the

process, while the two complement each other; as explained by Warren (2008: 101): “Process is product in a state of transformation, whereas product is process suspended.”

At this point, it should once more be recognized that arts therapies practice requires specialist skills and training in psychotherapy principles and ongoing supervision to address the complexities of this work. McNiff recognizes (1981: 60) that being a therapist is an art in itself and requires “an ability to be consistently oneself within the multiplicity of roles and interpersonal engagements that characterize the psychotherapeutic process.”

2.2.2.3 Practice standards in arts therapies

Since the year 2000 arts therapists’ practice in the UK, similarly to other allied health professions, is regulated by the Health & Care Professions Council (HCPC), former Health Professions Council. In addition, professional Associations dedicated to each of arts therapies modalities offer clinical guidance and supervision to their members, establish standards of good practice by developing Codes of Ethics and promote continuous professional development by offering training opportunities. Those Associations include: British Association of Art Therapists (BAAT), British Association for Music Therapy (BAMT), Association for Dance Movement Psychotherapy UK (ADMP UK) and British Association of Dramatherapists (BADth).

While general standards of practice for arts therapists are available from the Health & Care Professions Council (HCPC 2013) and enriched by codes of practice from the mentioned bodies, guidelines to address the specifics of working with depression or in a mental health setting have not been formally established. Since arts therapists incorporate diverse frameworks and influences in their practice, it seems safe to assume that establishing specific regulations for working with depression would not be feasible without suitable research. Whether such guidelines would be appropriate given the complex and ever changing context of individual therapy process and diversity of depression, remains open for discussion. However, an opportunity to access recommendations for practice with depression, based on quality research, would potentially bring multiple benefits. The knowledge could increase arts therapists’

willingness and confidence in addressing depression in their practice and could potentially enable further efficacy and effectiveness studies by making arts therapies interventions more transparent.

2.2.3 Making connections: Arts therapies and depression

The relationship of arts and depression is complex and has been widely explored in literature (Pöldinger 1986). A link between manic depression and creativity has been postulated (Hershman & Lieb 1998) but will not be explored here, while this project concerns unipolar depression specifically. Generally creativity seems to be “more closely associated with mental wellness than symptoms of psychopathology” (Spaniol 2001: 230) and many layers of depression have been uncovered through the use of artistic media within the therapy space and more informally in a seclusion of own homes.

Artists who have suffered from depression often attempted to depict and express the nature of their condition using familiar arts media. Engagement in creativity has been acknowledged on numerous occasions as invaluable helpful in the recovery process. Accounts of using arts intentionally in the process of self-help are common and include various media, including visual arts (e.g. Nicholls 2012), music, dance, dramatic expression and combination of arts (e.g. Nicholson 2012). While artistic expression seems to offer a relief and be supportive in recovery, Salzman (1996) notices that depression often tends to interfere with the creative process and “restoration of the creative function” may need to be facilitated through therapy.

Psychotherapists themselves often choose to share own accounts of the experiences of depression (e.g. Manning 1994). Possibly the most profound use of images, poetry and other arts in the process of self-healing was demonstrated by Carl Gustav Jung in his Red Book (Jung & Shamdasani 2009) – an account of the powerful process of creative engagement and its potential to heal as well as an arts-based enquiry into own personal development.

A relatively recent publication portraying depression through the use of mostly images with short meaningful descriptions (Johnstone 2007) has proven extremely popular among those, who suffer from the condition and recognise its features in the drawings –

an anecdotal evidence for expressive potential and healing power of image in depression in particular.

2.2.3.1 Arts therapies in diagnosis and assessment of depression

Early literature on arts therapies and depression concerned mostly the therapies' potential to diagnose and assess the severity and other features of the condition. For example, Fisch et al. (1983) considered description of non-verbal behaviour and movement patterns of depression sufferers helpful in initial assessment while Pavlicevic & Trevarthen (1989) used music improvisation as a diagnostic tool. Forrest (1978: 99) additionally postulated that art therapy "facilitated more precise identification of the precipitating cause of the patient's hospitalization".

In art therapy in particular drawing tests had been developed, which hoped to assess the nature of depression and led to therapists focusing on the formal qualities of artwork in search of understanding of the condition. Such approach was criticised by McNiff (1981: 31), who commented that "art created by clients/patients tends to be uniformly approached with a presumption that it will be a manifestation of whatever is wrong with the person." It was postulated that instead of striving to determine causes of mental-ill health, arts therapies could explore their potential for treatment.

While no longer as common, research in art therapy in particular continues to explore the diagnostic value of images. In a relatively recent study (Mitic 2006) features of drawings created by patients with depression showed correlations with the Hamilton scale often used to assess symptoms of the condition. However, another project concluded with less promising results as for diagnostic value of images (Wallace et al. 2004). Another study (Montenegro Medina & Paredes Merino 1996) demonstrated how drawings might be used to assess severity of depression and listed several features associated with the condition including: concern with filling the page, missing or fragmented relations to objects, presentation on negative feelings and various elements drawn with a ruler.

Nowadays, more attention in research is given to arts therapies' potential to heal and exploration of the mechanisms which lead to psychological change.

2.2.3.2 Arts therapies in the treatment of depression

For the reasons mentioned in section 2.2.1.4, other possible therapeutic interventions for depression are worth investigating and arts therapies might present a valuable alternative. Besides, there is anecdotal evidence that arts therapists address depression in their practice and, given the prevalence of the condition, it is likely that knowledge and expertise in the field is growing.

SIGN clinical guideline 114 (2010) mentions art therapy and music therapy as possible treatments, stating however that there is not enough quality evidence to support their effectiveness. While NICE guideline 90 does not make a direct recommendation for arts therapies, it suggests that whenever depression “has failed to respond to various strategies for augmentation and combination treatments”, a referral to “a practitioner with a specialist interest in treating depression, or to a specialist service” (NICE guideline 90: 35) should be considered, which may potentially include arts therapists experienced and interested specifically in the treatment of this condition.

A booklet for depression sufferers (MHF 2006) developed by Mental Health Foundation, a leading mental health charity, mentions music therapy and art therapy as treatment options but classifies them, quite misleadingly, as types of talking therapies. Also, NHS Quality Improvement Scotland Practice Development Network produced an informative leaflet for patients, explaining the nature of arts therapies and acknowledging their contribution to promoting emotional wellbeing of adults with mental health issues.

These examples seem to indicate that there is a growing interest in arts therapies as possible treatment options, but unavailability of quality evidence often prevents further developments and establishing of the disciplines alongside other trusted psychotherapeutic interventions with more pronounced evidence.

2.3 Research in arts therapies and depression

While a link between arts therapies and depression has been established on the above pages, the following sections will explore this connection further. Considering the main interest of this project, available literature was searched for information allowing to establish how arts therapists work with depression and whether and how this practice is evaluated. Mirroring arts therapies interest in both the outcomes and the process, the literature search was focused on what happened in the therapy and what the results were in hope to offer comprehensive understanding of the practice, as available in the current point in time. Gilroy (2006: 3) similarly recognises that both “process as well as outcomes” are equally important in arts therapies research.

Systematic literature searches were performed over the course of three years in order to offer this brief review. Initial search took place over the period of 10/2010 to 03/2011 and was repeated in the months of 06/2013 to 10/2013. Searches for journal articles were performed primarily using electronic databases, including Medline, PsychInfo and CINAHL. Books and further texts were browsed using library catalogues available from the Queen Margaret University, the University of Edinburgh and the National Library of Scotland. Additional searches were performed within Google Scholar. Not less importantly, conferences and research seminars offered invaluable opportunities for identifying relevant literature and gaining knowledge on current developments in the field.

It needs to be noted at this point that drawing on differences between arts therapies and arts activities previously highlighted, efforts were made to review arts therapies research specifically and not studies which either describe or evaluate arts potential in relieving symptoms of depression. However, in practice it appeared that available definitions may not be specific enough, while it often proved difficult to clearly distinguish between the two. As observed by MacDonald et al. (2012: 3), research in arts therapies and the psychology of arts often complement each other and it is recognised that on singular occasions studies not fully meeting the criteria of arts therapies research could have been included in the presentation.

2.3.1 Research in arts therapies

Practitioners-researchers in the arts therapies acknowledge that the field is not easy to study, while therapy, being a “process” is very difficult to examine (Meldrum 1999:179). Some claim that the concepts of therapeutic process and research almost contradict each other (Grainger 1999). It has been a common conviction among arts therapists that “therapy is an art form whose creativity is lost if too closely examined” (Meldrum 1999: 179) and therefore research has not been in the focus of those therapists. Alongside other practical reasons, including unfamiliarity and inexperience with research methodology, Edwards (1996) addresses the psychological issues that might prevent arts therapists from engaging in the research, e.g. the fear of criticism and failure.

There is, however, a growing belief that arts therapies can and should be researched creatively, realistically and objectively (Meldrum 1999: 187) with recognition of the importance to research “process as well as outcomes” (Gilroy 2006: 3) and using appropriate methods. Many arts therapists have now accepted research as a creative process (Meekums 1996: 136). Payne (1996) even mentions that it is something which arts therapists owe to their clients. Similarities rather than differences between research and therapeutic practice seem now to be recognised which has been well summarized by Gilroy: “The arts and therapeutic practice involve relationship and are about individuals and diversity, and research comprises a hugely diverse range of methods and practices. All open up the world.” (Gilroy 2006: 3)

The recent demands of evidence-based practice have of course influenced arts therapists’ thinking about research and are steadily leading to producing increasingly higher quality studies, with added value of creativity, more often visible in innovative methodologies. Arts therapies research may therefore take benefit from its foundation in the artistic process

“rather than succumbing to an overreliance on Western rationalism to effect therapeutic change (...). However, this does not negate the necessity for art therapists who work closely with psychotherapists to be able to explain the art therapy process in a manner that is comprehensible within the prevailing mental health theoretical systems.” (Coleman & Farris-Dufrene 1996:14)

Often the most respected research models for evaluating clinical practice, like randomized clinical trials, do not seem suited to art therapies realm and on occasions fail

to generate a better understanding for this reason. The discussion on whether arts therapies should engage in research on terms enforced by the requirement to provide evidence remains open. Very recently, Holttum (2013) argued that one of the largest randomized clinical trials on art therapy rather than offering meaningful evaluation

“exemplifies many problems inherent in the pervasive research culture of putting numbers onto complex human interactions and calculating their value for money, sometimes at the expense of really understanding what is going on.” (Holttum 2013: abstract)

The need seems to be apparent for development of innovative and creative research methodologies with an ability to capture the essence of therapy process while remaining meaningful for other healthcare practitioners and service providers. Arts therapists’ active engagement in the process seems crucial, the importance of which has been recognized by all of Arts Therapies Associations. British Association for Music Therapy now offers an introductory course on research methodologies to its members as part of continuous professional development, while British Association of Dramatherapists held a research-oriented event meaningfully named “Beyond Value – Evidencing the Unmeasurable”.

Moreover, over the past few years an increase in arts therapists’ engagement in promoting their practice and interest in evaluation has become apparent in thematic conferences and seminars (e.g. European Consortium for Arts Therapies Education regular conferences) and the International Centre for Arts Psychotherapies (ICAPT) has been recently established and held a Research Forum for the first time in 2013.

While it seems predictable that research will become a steadily growing interest among arts therapies practitioners, development of creative methods and innovative methodologies (Frankel 1999), finding “tools and instruments as suited to therapeutic practice” (Meldrum 1999: 187) and employing multimodal approaches to research would promote this engagement and a meaningful dialogue between the disciplines and healthcare settings.

2.3.2 Arts therapies practice with depression

The question about the essence of therapy process and what aspects exactly lead to a desired change had been open since the very beginnings of arts therapies. Many authors mention and list therapeutic factors in arts therapies (e.g. Gersie 1996 on dramatherapy, Schmais 1985 on dance movement therapy). While the works often focus on foundations of psychotherapeutic interventions with added value of arts media and the role of artwork as significant object in therapy, they rarely mention tools or methods suited to particular client groups with varied needs, including depression.

The most comprehensive description of arts therapies practice in general was by far offered by Karkou & Sanderson (2006), who have mapped the field using rich research evidence. Although particularly valuable, this work does not include any information on the specifics of arts therapies practice with depression, apart from mentioning that working with a number of different client groups is common (Karkou & Sanderson 2006), which suggested that depression may likely be addressed as part of practice focused more generally on mental health. There is no confirmation of this theory.

At the time of the beginning of this project (2010), although single accounts from arts therapists on how they worked with depression were available, the described aspects of work were fragmented, did not form consistent patterns of practice and often concerned patients / clients experiencing depression as a symptom secondary to other diagnoses or within a prevailing developmental stage.

The above largely remains true in 2013, although a particularly relevant and valuable work has recently been presented by Blomdahl et al. (2013), who offer interesting results of an attempt to describe art therapy practice with depression in a review of 16 relevant articles. The paper presents eight therapeutic factors, which are believed to be healing in the treatment of depression; these include: self-exploration, self-expression, communication, understanding and explanation, integration, symbolic thinking, creativity and sensory stimulation. (Some of these areas will be later referred to in chapter 5 (Core discussion), as overlaps with current findings were observed).

No similar reviews are available in other arts therapies and the description of practice remains enigmatic. Among further developments, a recent publication of partial results

from this thesis (Zubala et al. 2013, see also section 4.2) is hoped to have added some value to the general picture of arts therapies practice with depression.

While, as mentioned above, currently available literature offers fragmented knowledge, it will not be further presented here to avoid non-scientific conclusions. It is acknowledged that a number of case studies have been published, which more often than evaluation concern therapeutic factors or other aspects of practice. These will, however, be discussed in the following section to offer more clarity to the presentation.

2.3.3 Evaluation of arts therapies for depression

Arts therapists commonly engage in evaluation of own clinical practice with depression using reflection and supervision as main tools. In some case studies there are accounts of creative use of client evaluation, after individual sessions (e.g. Barry 2006 on DT) or at the end of a course of therapy (Batcup 2008 on DMT). While these accounts rightfully increase the perceived value of arts therapies, they most often do not apply enough scientific rigour to offer a robust evaluation.

Furthermore, the hierarchy of evidence needs to be considered in informing evidence based practice (Evans 2003) and arts therapies literature concerning depression do not include many studies on the high levels of evidence. Research which addresses evaluation of arts therapies for depression will be further presented in inversed order of commonly accepted hierarchy of evidence, i.e. starting from single case studies through studies of quasi-experimental design and randomized clinical trials to the highest valued research (systematic reviews and meta-analyses).

At this point, it is important to distinguish research on the impact of arts therapies on depression as primary diagnosis and depression as a symptom of another condition or secondary diagnosis. Since co-morbidity of depression with other conditions, either physical or mental health-related, is astonishingly common and far exceeds numbers of diagnoses of pure major depressive disorders (Chisholm et al. 2003), it is not surprising that researchers often report effects of treatments on levels of depression in study participants whose primary diagnoses are different. Similarly, research in arts therapies includes many studies, in which therapeutic effect on depression is evaluated in

populations of participants suffering from other, often physical, conditions (e.g. cancer, heart conditions), experiencing a particular difficulty affecting their mood (e.g. substance dependency, prison population) or whose depression is co-morbid to other mental health-related problems (e.g. dementia).

While this project focuses on depression as primary diagnosis (often referred to as major depression or unipolar depression), most relevant research will be presented first and followed by significant studies, in which depression is secondary or a symptom of another condition. Similarly, while adult depression is of a particular interest to this research, major studies which concern older or younger populations will be mentioned briefly once literature on art therapies for depression in adults is explored.

The table below (Figure 1) includes main arts therapies studies concerning depression. Column entitled “depression as diagnosis” gathers research most relevant to the current project, i.e. focusing on depression as primary diagnosis in adults (16-65 year olds). Column “depression as symptom” includes studies in which depression was closely related to other conditions or which concerned depression in older adults and adolescents / children. Arts related studies which did not meet the criteria of arts therapies intervention, although on occasions mentioned in further sections, were excluded from this table, i.e. studies in which engagement in arts activities was in focus but no or not enough attention was given to therapeutic relationship (e.g. Jones & Field 1999, Rajewski et al. 1981, Lai 1999, Bodner et al. 2007) and studies in which therapy related to arts therapies was offered (Hamamci 2006).

It is important to observe that the table additionally indicates differences in the quantity of research on depression in separate disciplines of arts therapies. It may easily be noticed that there are more studies available in music therapy than in any other of the arts therapies and that the amount of research in dramatherapy and depression is very limited. Moreover, quantitative research on primary depression in adults is sparse, while there are significant developments in the fields of music therapy and art therapy in research which includes depression as secondary to other conditions. Art therapy research seems to be especially interested in cancer patients, while music therapy often concerns older adults with dementia, as well as substance abuse.

arts therapy	depression as diagnosis	depression as symptom
	primary adults	secondary related to other condition or age group
Case studies (evaluative / including client experience / describing aspects of practice)		
MT	Aldridge et al. 1990 Beebe & Wyatt 2009 Booth 1998 Byrne 1982 Davies 1995 La Torre 2003 Lin et al. 2010 Summer 2011 Tonn 2003	Dobrzynska et al. 2006 (older adults) Goldberg et al. 1988 (brain damage) Hendricks & Bradley 2005 (family with depressed adolescent) Martinez 2009 (dialysis patients) Montgomery et al. 2009 (post-stroke depression) Odell 1988 (psychiatric population) Pickford 1983 (complex presentation) Redinbaugh 1988 (older woman) Witte et al. 2011 (older adult)
AT	Aldridge et al. 1990 Bliss & Wilborn 1992 Branch 1992 Coreno 2007 McNamee 2004 Price 2009 Reynolds et al. 2008 Rosen 1993 Thorne 2011	Dalley 1980 (psychotic symptoms) Gussak 2006 (prison population) Landgarten 1983 (older people) McCaffrey 2007 (older adults)
DMP	Genetti 2011 Heber 1993 Trautmann-Voigt et al. 2002	Batcup 2008 (psychiatric population) Blatt 1996 (prison population) Ginsburgs & Goodill 2009 (cancer patients)
DT	Barry 2006 (post-natal depression) Dokter 1996 Grainger 2008 Maria Gisela 2009 Rawlinson 1996	Forrester & Johnson 1996 (psychiatric population) Reinstein 2002 (older adults) Van den Bosch et al. 2005 (older psychiatric population)
other	Bush 1988 (integrative: GIM and mandalas) Goldstein-Roca & Crisafulli 1994 (integrative creative arts therapy) Mazza & Price 1985 (integrative arts therapies)	Perry et al. 2008 (creative arts for post-natal depression)

<i>Clinical trials (RCTs / quasi-experimental designs)</i>		
MT	Brandes et al. 2010 Castillo-Perez et al. 2010 Erkkilä et al. 2011 Kumar & Singh 2013 (protocol) Lai 1999 Rajewski et al. 1982	Albornoz 2011 (substance abuse) Burns 2001 (cancer patients) Chan et al. 2009 (older people) Chen 1992 (older people) Chou & Lin 2012 (dementia) Chu et al. 2013 (dementia) Guetin et al. 2011 (Alzheimer's disease) Hanser & Thompson 1994 (older adults) Hsu & Lai 2004 (psychiatric population) Hwang & Oh 2013 (alcohol dependence) Myskja & Nord 2008 (dementia) Odell-Miller et al. 2006 (psychiatric population) Schwantes & Mckinney 2010 (immigrants) Silverman 2011 (substance abuse) Wan et al. 2009 (cancer patients)
DMP	Heber 1993 Jeong et al. 2005 Koch et al. 2007 Stewart et al. 1994 Xiong et al. 2009	
AT	Thyme et al. 2007	Ando et al. 2013 (cancer patients) Bar-Sela et al. 2007 (cancer patients) Chandraiah et al. 2012 (psychiatric patients) Crespo 2006 (immigrants) Field & Kruger 2008 (HIV-related depression) Gussak 2006 & 2009 (prison population) Thyme et al. 2009 (cancer patients)
<i>Systematic reviews</i>		
MT	Maratos et al. 2008 (only 1 study on adults)	
DMP	Meekums et al. 2012	
AT	Geue et al. 2010 (cancer patients, depression secondary) Blomdahl et al. 2013 (identification of therapeutic factors)	

Figure 1: Research in arts therapies and depression: core studies (MT = music therapy; AT = art therapy; DMP = dance movement psychotherapy; DT = dramatherapy).

It needs to be acknowledged that, while every effort was made to include as many relevant studies as possible and the most significant of them have certainly been identified, this list is most likely not complete. Following sections will present some of the most important features of the studies above and several interesting projects, which could not be included due to not meeting the criteria previously described.

2.3.3.1 Case studies: client experiences and aspects of practice

Case studies in arts therapies often offer interesting reading rich in insights on selected aspects of clinical practice. Such texts seem to be intended specifically to guide the practice of other practitioners in the same arts therapies discipline. As such, while being an invaluable source of information for arts therapists themselves, they tend to offer limited value to other clinicians in the field of mental health.

Some case studies, however, focus on evaluation of practice and sometimes mention accounts of client experiences to indicate areas in which arts therapies may benefit clients suffering from depression.

Since this project is concerned with arts therapies practice in the UK in particular, the discussion will begin with briefly mentioning literature most relevant to clinical practice in Britain. Presentation of studies which focus on depression as a primary diagnosis will follow to conclude with brief description of projects including depression as not necessarily the predominant presentation.

Research on arts therapies and depression in the UK includes several case studies from the 1980s (Odell 1988 on MT; Dalley 1980 on AT) and a few in more recent literature. However, these studies most often do not concern depressed adults specifically, but either older people (Van den Bosch et al. 2005), mixed groups of clients with different diagnoses (Batcup 2008) or clients whose depression is secondary to their other mental health problem (Blatt 1996). Thus, the picture of arts therapies practice in the UK, and client experience of therapy, certainly remains incomplete. Although studies from around the world offer further understanding of general practice, it needs to be acknowledged that some of these may be culturally specific and may not be transferable.

a) Depression as a main diagnosis (case studies)

Music therapy

An interesting case study in music therapy (La Torre 2003: 131) explains how tones and sounds were used to enhance therapeutic relationship. The author concludes that “the concept of making sounds frequently helped [the client] to release her feelings and served as a way to relax and refocus into a balanced place.”

Other research in music therapy worth attention includes the description of emotional, cognitive and behavioural transformation after the treatment in Taiwan (Lin et al. 2010), which increased understanding of the psychological growth experiences of depression sufferers during the Bonny Method of Guided Imagery and Music.

Another case study (Davies 1995) discusses the role of loss in depression and argues that music therapy empowers clients to access and freely express feelings, which can subsequently be verbalised with confidence.

A specific music therapy intervention, the Bonny Method of Guided Imagery and Music (GIM), has been evaluated for its potential to address depression in several case studies. In one of these (Summer 2011), “re-educative music and imagery” offered new perspectives to the client and helped him identify internal supportive resources. Another paper (Beebe & Wyatt 2009) offers a brief literature review on the use of GIM and a personal account of participation in the therapy, where the author shares: “In discovering myself, I had permission to be myself—faults, gifts, and all. In essence, the music guided imagery set me free” (Beebe & Wyatt 2009: 31). One article (Booth 1998: 15) presents an evaluation of a music programme based on the method of GIM, which focused specifically on aspects of clinical depression and this aimed to “reflect a multiplicity of clear and evolving relationships, including an apprehendable musical architecture”.

An integration of music and art therapies has been successfully used to address depression in a case study of one woman (Aldridge et al. 1990), whose confidence grew when techniques of repetition and imitation were used. It is reported that such tools helped the client to relax and thus formed a basis for creative exploration, which was suggested in further therapy.

Other studies in music therapy concerned female depression in psychosomatic clinics (Tonn 2003) and an account of improved depression in an older woman following seven music sessions (Byrne 1982).

Art therapy

An interesting study in British literature contains the narratives of older women recalling their experiences with art therapy from their midlives, when they suffered from depression in relation to marital breakdown (Reynolds et al. 2008). Although the study provides an interesting account of clients' experiences, only "one of the participants had experienced formal art psychotherapy, and the other two had engaged in art-making in another therapeutic context" (Reynolds et al. 2008: 204) which makes it debatable whether the study can be considered an arts therapies research. In addition, very specific circumstances which lead to clients' depression may not offer enough transferability for practice with this condition in general, but the study includes some valuable conclusions like: "some participants may look back over two decades or more and still portray a therapeutic experience as life-changing" (Reynolds et al. 2008: 212). Other points are more relevant to the clinical practice itself and, for example, include an interesting observation of how one particular participant "appreciated the opportunity to work on many pieces, in order to regain a sense of vitality and to demonstrate new-found creativity", while others "valued the slow pace of art-making to regain contact with the essential self, to work through decisions and to affirm their self-worth" (Reynolds et al. 2008: 212.)

The work of Rosen (1993) offers a groundbreaking radical approach to recovery from suicidal depression and demonstrates how art therapy offers opportunities to confront images and symbols emerging from internal struggles. The author believes that such confrontation has the power to release creative energy, transform and lead to the reclaiming of self.

An interesting study (McNamee 2004) proposes the use of scribble drawings combined with verbal therapy to address depression and concludes that the nonverbal process was "driving" and preceded verbal expression, which led the client to better understanding of own condition.

Other case studies (Branch 1992; Bliss & Wilborn 1992) demonstrate how a symbolic process is used to facilitate growth and one author (Thorne 2011) presents own experience of working with depression, using image-specific means of communication. The study of Aldridge et al. (1990) has been mentioned earlier in more detail, as it integrates art and music therapies in addressing depression.

It is important to notice that Masters programmes in art therapy often require students to present research-based dissertations and two such works concerning depression have been identified. One Masters thesis (Coreno 2007) aimed to develop a workbook with certain tasks and activities within art therapy sessions identified as helpful in addressing depression. The second work (Price 2009), similar in theme, attempted to develop a 12 week therapy curriculum for the treatment of depression, following questioning therapists on how they work and enriched with information from literature.

Dance movement therapy

In dance movement literature only three papers directly related to depression were identified. Trautmann-Voigt et al. (2002) report on treatment of a male patient, describing body language clues to his depression and explaining how the therapy was used to release tension and achieve an emotional breakthrough. Additional six case studies are presented within the work of Heber (1993), whose research followed a generally quantitative design. Recently, a Masters thesis furthering understanding of how dance movement therapy may assist adults with depression has also been produced (Genetti 2011).

Dramatherapy

The work of Dokter (1996) provides an extensive and valuable account of a dramatherapist's clinical experience of brief therapy with depressed clients and includes several case studies, which all give an insight into the therapeutic process and specific interventions used with this client group. While extremely valuable from the perspective of clinical practice, this paper unavoidably is an account of a single therapist and her work with a very limited number of clients and therefore cannot provide a quality evidence for the effectiveness of dramatherapy with depression. Nevertheless, Dokter's

reflections from the use of brief model of therapy offer some rich insights into the specifics of dramatherapy work with clients suffering from depression, including recognised advantages of brief approach for clients' motivation and commitment as well as acknowledgement of benefits of individual therapy sessions preceding group therapy.

Another piece of insightful writing is offered by Grainger (2008), who highlights the common in depression tendency to withdraw and avoid new contacts and explains how dramatherapy supports clients in leaving preoccupations with themselves behind and in consequence facilitates connections with others.

An interesting study (Barry 2006) evaluated dramatherapy groups for women with postnatal depression by including very positive accounts of client experiences, collected through the use of questionnaires after every session. Authors also describe how they aimed to relieve anxiety in first few sessions by starting therapy with what had already been known to clients and preceded depression. In further session themes including unmet expectations, loss, anger, resentment and sense of self were explored.

Another project (Rawlinson 1996) explores the features of depression and anxiety through the use of dramatherapy, sandtray therapy and dreams in three case studies. A Masters thesis has also been identified (Maria Gisela 2009), which explores how dramatherapy helps clients find meaning, often lost in depression.

Integrative arts therapies

Literature also includes a few case studies, which focus on primary depression addressed through a combination of arts therapies methods and media rather than a single arts therapies discipline. These studies are relatively old and include: an account of a brief ICAT (integrative creative arts therapy) for a young women diagnosed with major depression (Goldstein-Roca & Crisafulli 1994), a description of the use of Guided Imagery and Music method combined with mandalas (Bush 1988) and a case study of six adults whose depression was treated through the use of music integrated with poetry (Mazza & Price 1985).

b) Depression as symptom (case studies)

Music therapy

Several music therapy studies concern individual clients, whose depression is secondary or, as in the case of the first study to be described, a non-heterogeneous group of people. One such study offers observations from a group music therapy (Odell 1988) following a psychodynamic model and intended for adults experiencing various mental health problems. It is highlighted that encouraging clients to take responsibility for what happens in the therapy is crucial for successful outcomes. A single case of a patient with bipolar disorder is included, but although it describes the positive impact of therapeutic process on general wellbeing of the client, it does not account for changes in the extent of depression and obviously concerns presentation of depression with psychotic features - not the subject of this research.

In a significant number of music therapy studies depression among older people, often suffering from dementia, is addressed. One paper (Dobrzynska et al. 2006) presents case studies of four elderly women who took part in music therapy combined with cognitive behavioural therapy (CBT), while another reports on the progress of a single client (Witte et al. 2011) within a group therapy. Authors of another single case study conclude that once an elderly client “developed a system of communicating through music” her participation in social activity groups increased, which in consequence led to the formation of a social support system.

One original study (Hendricks & Bradley 2005) presents a successful integration of music therapy with interpersonal psychotherapy (IPT) in the course of family therapy where an adolescent's depression was the main presentation. Other case studies concern the treatment of depression following stroke (Montgomery et al. 2009) and brain damage (Goldberg et al. 1988).

Art therapy

Dalley (1980) presents a case study on art therapy with a patient suffering from depression with psychotic symptoms. The patient was asked to rate her feelings after

every of 15 sessions and the author concludes that using such evaluation helped to understand the therapeutic effect and the process.

Another single case study within a larger quantitative research (Gussak 2006) gives insight into art therapy practice with prison population and the author reports on the progress of one of the depressed inmates, claiming that following art therapy sessions he presented an extended sense of self and more awareness of his environment, resulting in “much brighter spirits”.

Art therapy practice with older population experiencing depression may be illustrated by the two case studies. First project (McCaffrey 2007) offers a comparison of group art therapy with individual and group garden walks within a nursing home. Evaluation was based on focus groups with participants following the treatment. All three interventions were found helpful in reducing depression and no differences were detected. Another paper (Landgarten 1983) proposes some unique features of art therapy, which the author considers helpful for elderly people suffering from depression; these include the potential of artwork and creativity to: highlight clients’ vitality, express anger and aggression, provide nurturance, facilitate transitions, establish therapeutic alliance, discourage rumination and detect suicidal clues.

Dance movement therapy

An evaluation of dance movement therapy sessions for adults with a variety of mental health problems was attempted by Batcup (2008). The study includes client experiences, collected through the use of questionnaires, and reports that the treatment was received well and was valued by both the participants and the staff of the hospital.

A different paper (Ginsburgs & Goodill 2009) reports on the development of an evidence-based 10 week programme for women with gynecological cancer, which includes addressing depression as one of major aims.

Dramatherapy

Only a few case studies provide slightly more insight into the area of dramatherapy. Forrester & Johnson (1996) focus on challenges and evaluation of brief group

dramatherapy model in psychiatric hospital, where the group was heterogenous with about half of the members with symptoms of depression. Another study (Van den Bosch et al. 2005) concerns older people experiencing a mixture of mental health problems.

Reinstein (2002) offers an interesting reading on dramatherapy used to address depression in elderly people. In this study, a psychodynamically oriented dramatic play was used to safely explore emotional territory and the author concludes:

“Through dramatic play and the witnessing of the work by members of the group, elders can, through metaphor, articulate feelings that might ordinarily be difficult to express directly. Defences constructed over a lifetime can, in these circumstances be breached, if only temporarily.” (Reinstein 2002: 15)

Other arts

Although not strictly a therapy, a case study of a creative arts group for women experiencing post-natal depression was presented by Perry et al. (2008). It seems appropriate to include this study here, while the authors stressed the therapeutic value of the group and included client experiences in the overall positive evaluation.

2.3.3.2 Clinical trials: efficacy / effectiveness

a) Depression as a main diagnosis (clinical trials)

Music therapy

An ambitious project was undertaken very recently by researchers in Finland (Erkkilä et al. 2011), whose study measured the effectiveness of improvisational music therapy on adults affected by unipolar depression. The scale of the research was significant (with just under 80 participants), it was designed well and with attention to methodological clarity. Results were promising and indicated statistically significant decrease of depression levels measured in 3-month follow-up. However, results in 6-month follow-up, although still indicating lower depression scores, were not statistically significant. Up to date the study provides possibly the most robust evidence for efficacy of music therapy for major depression.

Another important research was undertaken by Castillo-Perez et al. (2010) in Mexico and involved comparison of music therapy with a form of psychotherapy (conductive behavioural therapy). Authors suggest that, while both therapies proved helpful, music therapy offered better improvements than psychotherapy. Although it is an interesting study and a fairly large study, it may be debatable whether the intervention offered (self-administered music listening sessions every day and group music session once a week) could be classified as music therapy (further explored in the following section).

Another randomised controlled study concerned depressed women in Taiwan (Lai 1999) and included qualitative results based on questionnaires completed by participants after music therapy sessions. Although only a very mild effect of therapy on mood was detected and no differences between a control and an experiment group were found, changes in physiological responses were reported and qualitative findings confirmed participants' acceptance of music therapy sessions.

A study from Poland (Rajewski et al. 1982) on the treatment of endogenous depression offered interesting conclusion that music therapy was beneficial for hospitalised patients provided that therapeutic activities were relatively simple and of a guided character. No improvements were detected when activities were of a more complex or improvised character. However, it needs to be noted that the study concerned hospitalised patients, i.e. suffering from more severe depression and the results should only be interpreted in this particular context.

Other relevant research includes evaluation of a specific receptive music therapy intervention (Brandes et al. 2010) which resulted in reduced symptoms of depression and high compliance rates. A protocol for a promising study to compare music therapy with medication has also recently been developed but the results remain unknown at the point of writing (Kumar & Singh 2013).

Dance movement therapy

Possibly the most substantial study on dance movement therapy and its role in alleviating symptoms of depression had been undertaken in Korea (Jeong et al. 2005). Here, significant improvements in negative psychological symptoms (including depression) have been observed in adolescents after 12 weeks of treatment, as

compared to a control group. This study, although with promising results, did not offer opportunities for follow-up measurements and concerned 16 year old adolescents only.

Dance movement therapy had also been researched in Canada (Stewart et al. 1994), where it was found to improve the mood of 5 out of 12 participants with diagnosed depression. The unusual single case study design offered immediate measurements of mood (only one aspect of depression) after therapy sessions, but could not assess their long term impact.

In Germany a single dance intervention compared to exercise and music interventions proved effective in decreasing depression (Koch et al. 2007) in participants with varying degrees of depression. However, the brevity and a very specific nature of intervention do not resemble usual dance movement therapy practice and therefore the study's relevance to DMP research may be debatable.

In another study (Xiong et al. 2009) dancing therapy was evaluated following four week treatment of hospitalized patients diagnosed with depression. The reported "healing rate" was higher than in a control group, but the study concerned sufferers of more severe depression, who were additionally receiving pharmacological and psychological therapy.

Another study from Canada (Heber 1993) assessed the effectiveness of dance movement therapy in psychiatric clients diagnosed as underactive or depressed. The study design included collection of qualitative data from observation and questionnaires completed by participants. Clients offered positive cognitive and psychological responses to treatment and increased self-esteem was identified in those, who consistently participated in therapy.

Art therapy

A valuable (and the only identified) RCT study on art therapy was undertaken in Sweden (Thyme et al. 2007), where two forms of brief (10 sessions) psychodynamically oriented psychotherapy were compared: verbal therapy and art psychotherapy, with conclusion that both were effective for women suffering from depression.

b) Depression as symptom (clinical trials)

Music therapy

An attempt to investigate the effectiveness of arts therapies for adults with continuing mental health problems in the UK has been made by Odell-Miller et al (2006). Among 25 patients involved in the study only six were diagnosed with depression. The research which combined quantitative and qualitative methodology did not provide significant numerical results due to small numbers of participants recruited in relation to the complexity of hypotheses but concluded that the patients used arts therapies well, recognising the added value compared with those attending talking therapies.

A study in Taiwan (Hsu & Lai 2004) addressed the symptoms of a major depressive disorder through the use of music with a group of participants compared to a control which included patients instructed to rest. Music listening sessions were offered every day over the course of two weeks. While positive changes were observed in both groups, a more significant decrease of depression was noted in participants who listened to music. As mentioned previously in the case of a study by Castillo-Perez et al. (2010), it is not clear whether the intervention may be classified as music therapy.

The substantial number of studies in music therapy have been undertaken with the participation of older people, among whom depression is common and often comorbid with dementia (Cha et al. 2009; Chou & Lin 2012; Chu et al. 2013; Hanser and Thompson 1994). In one particular study (Chen et al. 1992) music therapy combined with medication resulted in earlier improvements than in a control group and authors reported that participant in the treatment group remained calm and active and that “the atmosphere on the ward appeared to be somewhat harmonized so that it was beneficial to the nursing care” (Chen et al. 1992). Another promising pilot RCT from France concerns patients with mild to moderate Alzheimer’s disease (Guetin et al. 2011) and researchers from Norway (Myskja & Nord 2008) report on a significant reduction in depression levels among dementia sufferers in a nursing home once music therapy was resumed following several months of therapist’s absence.

Three recent studies included participants experiencing substance abuse and depression levels were measured following music therapy treatment. One of these studies (Albornoz 2011), an RCT, concerned substance abuse among adolescents and reported

significant improvement in depression on one of the used scales (HRSD) but not on the other (BDI). Hwang & Oh (2013) offered individual music therapy sessions to adults with diagnosed alcohol dependence twice weekly over the course of six weeks and reported no significant results but observed lower scores on depression scale following the treatment. In another mixed methods RCT (Silverman 2011) not significant but lower means of depression were observed in posttest and follow-up among inpatients in detoxification unit who underwent music therapy. In addition, participants reported higher perceived enjoyment, appreciation, will to continue the music therapy program, and positive cognitive changes.

Two studies have been undertaken with the participation of cancer patients. One project (Wan et al. 2009), although did not offer statistically significant results, concluded that participants reported a perceived positive change in mood. Another study (Burns 2001) offered promising results on GIM, but was a small-scale project and does not allow for claims regarding effectiveness.

Another small scale music therapy study addressed depression among Mexican immigrants (Schwantes & McKinney 2010: 22) and reported statistically significant effects and concluded that “culturally appropriate music therapy sessions may positively affect depression”.

Art therapy

Indication of positive effects of art therapy on depression was found in multiple studies on prison inmates in US (Gussak 2006, 2009). However, the results based on two measuring scales (BDI-II and FEATS) were inconclusive.

Three studies in art therapy with cancer patients reported promising results in lowering depression scores following the treatment. One study (Thyme et al. 2009) reported significant lower levels of depression in breast cancer patients in a 4-month follow-up of a five week therapy. Another study (Bar-Sela et al. 2007) detected lower median scores on a depression scale (HADS) in cancer patients, who took part in at least four art therapy sessions, and similar results were reported in another project (Ando et al. 2013), where an extremely brief therapy (two sessions) was offered.

Research in art therapy also includes a study on HIV-related depression (Field & Kruger 2008) and a culturally specific study with immigrants (Crespo 2006), in which a culturally adapted group art psychotherapy resulted in a significant reduction in depressive symptoms.

Other therapies

No quantitative research can be found on dramatherapy, while a Turkish study examined the efficacy of psychodrama integrated with cognitive behavioural therapy in the treatment of moderate depression (Hamamci 2006). The intervention was found to be equally effective to cognitive behavioural therapy alone in decrease of depression in university students. Although with common elements, psychodrama is a separate intervention to dramatherapy and belongs to verbal psychotherapies.

2.3.3.3 Systematic reviews

Two systematic Cochrane reviews have been offered in the field of arts therapies and depression, in particular in music and dance movement therapies. Both reviews include a very small number of studies, supporting the general notion coming from the literature review presented above that not enough quality evidence is available on arts therapies practice with depression.

The five studies reviewed by Maratos et al. (2008) offered research evidence that music therapy was perceived positively by people suffering from depression and indicated improvement in mood. However, because of relatively low quality of evidence in music therapy and depression research, this systematic review included a few studies, of which only one concerned adults between 16 and 65 years (Radulovic 1997) most of the other studies focused on older adults.

A new Cochrane systematic review on dance movement psychotherapy in the treatment of depression has recently been developed by Meekums et al. 2012. This work includes only three studies of which two have been considered relevant to the current research and presented above (Jeong et al. 2005; Xiong et al. 2009) and one is a yet to be

published study concerning body psychotherapy (Rohricht 2013) rather than DMP, although authors of the review recognize many similarities in the practice.

More evidence of effectiveness of high quality (Evans 2003) is required from other arts therapies disciplines, as recognized by Silverman (2010: 5), who postulates that “music therapy researchers should consider the levels of evidence when designing research studies”.

While there are no reviews in the two remaining arts therapies on their practice with depression, a systematic review of studies on art therapy with cancer patients is worth noting (Geue et al. 2010). Depression was the main outcome assessed and of seven papers included, six studies showed a statistically significant decrease of depression in participants following art therapy.

2.3.3.4 Additional considerations

Following the presentation of the most significant studies, several issues still need to be raised in order to leave the Reader with a complete picture of the nature of research in arts therapies and depression.

First of all, it is important to acknowledge that while some researchers report promising results from quasi-experimental design studies, their methodological quality is often either poor or the findings presented in not enough detail to claim credibility (e.g. Martinez 2009 on music therapy). Inadequate understanding of medical terminology commonly used in establishing hierarchy of evidence of health interventions sometimes result in false claims of effectiveness (e.g. Batcup 2008 on dance movement psychotherapy).

While there are many studies which examine the effects of music on wellbeing, including depression (e.g. Cooke et al. 2010, Stordahl 2010), in some reports it is not clear whether the researchers acknowledge the distinction between music therapy and music listening and often the therapeutic effects of music itself rather than music therapy are presented (La Torre 2003; W. Hsu & Lai 2004; Lai 1999). As a further example, an interesting project

was undertaken in Israel (Bodner et al. 2007) where listening to sad music seemed to have helped depressed participants in verbally expressing emotions.

While in the studies mentioned above no claims are made that music therapy was actually the intervention offered to participants, some studies are more confusing in what they hoped to research and what type of therapy was actually administered. For example, in the comparison of music therapy with psychotherapy in the treatment of depression in Mexico (Castillo-Perez et al. 2010) exposure to certain types of music rather than music therapy was offered, while authors quite misleadingly use the term “music therapy” throughout the report of the study. However, since what constitutes arts therapies has not been made entirely clear, this well-designed study is still worth attention and enhances evidence that music therapy may be effective in the treatment of depression. In another study (Jones & Field 1999) in a group of 30 depressed adults with greater relative right frontal EEG activation (associated with negative affect) frontal EEG asymmetry was significantly attenuated during and after the massage and music listening sessions, referred to as “music therapy”.

It also needs to be noted that there are a number of arts therapies studies available which include heterogeneous groups of adults or older adults suffering from mental health conditions, often inpatients within psychiatric settings. Such studies were intentionally excluded from a more detailed analysis (with an exception of Odell-Miller 2006 and Batcup 2008 – more relevant being British studies), as participants suffering from depression with no psychotic features often constitute a minority in this branch of research. However, in a more systematic review of arts therapies for depression, these studies could potentially offer value to the subject.

A review of projects addressing psychiatric patients in a particular area of music therapy has been offered by Gold et al. (2009), while Ritter & Low (1996) present a meta-analysis of studies in the discipline of dance movement therapy. Several other examples include: Chandraiah et al. 2012 (on art therapy), Körlin et al. 2000 (on creative arts therapies), Schnee 1996 (on dramatherapy for homeless mentally-ill adults), De l' Etoile 2002 (on music therapy for adults attending community mental health centre), Brooks & Stark 1989 (on effect of single session of dance movement therapy on psychiatric patients).

On a final note, it is important to highlight that, dissimilarly to what might be expected, apart from single cases (e.g. Thorne 2011) no arts-based research within the theme of arts therapies and depression could be identified. While only literature concerning depression was searched and research in other areas could potentially be very different, no further assumptions as to whether and how often arts therapists engage in arts-based research will be made. However, some authors (e.g. Ledger & Edwards 2011) postulate that more arts-based research is needed, as it has the potential to increase the authenticity of arts therapies practice.

2.3.4 Summary of research in arts therapies and depression

Comprehensive map of the field of arts therapies in the UK has been presented by Karkou & Sanderson (2006) and there are publications available which give a description of the patterns of practice of arts therapists in case studies of group work or individual clients' treatment (Payne 1996; Cattanach 1999). However, apart from several case studies (e.g. Reynolds 2008 and Liebmann 2007 on AT; Blatt 1996 on DMT; Emunach 1994 and Dokter 1996 on DT; Odell 1988 on MT), not enough can be found in British literature on how arts therapists work with depressed clients and the specifics of the treatment of this particular group. Even less has been published on the effectiveness of arts therapies and the level of evidence presented by isolated studies does not allow for clear conclusion on arts therapies' positive effect in the treatment of depression.

While not many studies can be found in British literature, there is significantly more evidence of research from around the world. Various independent studies undertaken recently worldwide suggest that arts therapies interventions result in significant positive change in mood and/or decrease of depressive symptoms of patients / clients with depression, whether as a primary or secondary diagnosis. However, arts therapies and depression still remain an underresearched area with not enough quality evidence for the effectiveness.

There are also differences between the quantity and the quality of research within four arts therapies disciplines with most of the research undertaken in music therapy, less in art psychotherapy and dance movement psychotherapy and virtually none or

insignificant in dramatherapy. However, it needs to be noted that the quality of dramatherapy literature on depression tends to be commendable and case studies, although few, offer valuable insights.

Especially in the last decade, there have been numerous accounts of attempts to develop research in the field of arts therapies and depression while it seems that many arts therapists worldwide have acknowledged the importance of research for the discipline. However, many of the studies up to date lack scientific integrity; especially those which present numerical results. There is, therefore, an increasing need for more research on the subject, which this study aims to address.

2.3.5 Current study

Gaps in the literature have been identified in both areas of interest in this inquiry: description of arts therapies practice and its evaluation. How arts therapists work with depression remained nearly unknown at the starting point of this project. Since then, a review of studies in art therapy (Blomdahl et al. 2013) has offered valuable insights, but description of practice of other arts therapies remains fragmented and inconsistent. Moreover, certainly not enough studies of high methodological quality may be identified to offer conclusions as to effectiveness of arts therapies for depression.

The current research is particularly interested in adult depression as a primary diagnosis and a very limited number of quality studies in the field could be identified. Relevant studies of acceptable methodological quality include: Erkkilä et al. 2011 on music therapy, Jeong et al. 2005 on dance movement therapy, and Thyme et al. 2007 on art therapy. Two available Cochrane reviews (Maratos et al. 2008, Meekums et al. 2012) confirm usual inadequacy of arts therapies research to assess effectiveness. It needs to be noted that the lack of research in the highest stages of the hierarchy of evidence demands further developments on the lower, case study level.

This project is thus committed to address the gap in available knowledge on how arts therapists address depression in their practice and to initiate the process of evaluation.

3. Methodology

3.1 Introduction

Since the presented research study uses complex methodology, incorporating various methods, paradigms and diverse data analysis, it is a recognised challenge to illustrate the whole research process in a clear and transparent way, which will now be attempted. Firstly, the research design and its background will be presented to offer an understanding of general principles, on which this project has been based, and its associated structural features. Subsequently, more details on the research process will be offered to include comprehensive illustration of the procedures, methods and data analysis in the two phases of this research. Since the two phases, although conjoined, are significantly different not only methodologically but also in their aims they will be presented separately. An attempt to further explain methodological connection between the two phases will complete the chapter.

3.2 Research design

3.2.1 Philosophical foundations

Pragmatism, as the main philosophical foundation of this research, inspired the use of mixed methodologies and underpinned the design of the study. While this philosophy stresses the importance of finding solutions to problematic situations and research is in its light a “practical action” (Muller 2005: 353), it allowed for flexibility in terms of methodology employed to gain different perspectives (Biesta and Burbules 2004: 108). Providing the best possible answer to the research question became a priority for the researcher, whose choice of methods reflected the needs of the question. Since pragmatism is far from being simplistic and “accepts both objective and subjective points of view” (Giatsi-Clausen 2010), in order to offer meaningful findings, the researcher needs to constantly engage in the process of reflexivity (Tashakkori & Teddlie 1998) while conducting the inquiry.

The concept of critical multiplism (Patry 2013), closely related to mixed methodologies, accepts that multiple approaches and multiple ways of collecting and interpreting data may be necessary to address certain research questions. This idea inspired the general design of the current study and the stage of data analysis in particular.

This research has been also influenced by postmodern thought in a belief that objectivity and modernist universality can and should be challenged especially in the field of arts therapies, where individual differences are in focus and the complexity of human nature is not only acknowledged, but also hugely valued. Postmodern theory “(...) has disputed the assumptions that different observations will coalesce into universal truths, that the observers are separate from the observations made, that scientists are impartial to the interpretation of their data” (Laugharne 2002: 208). Therefore, it is recognised that the research process is not deprived of a number of biases. However, these should not necessarily be seen as obstacles, but rather as additional and valuable data that can enrich the research with new dimensions. While there are no universal truths in postmodern theory, the research should aim for the best possible understanding of a problem or a solution, taking into account the fluidity of individual conditions and not claiming to provide the only acceptable answer. The “celebration of individual difference and non-conformity” (Laugharne 2002: 207) of postmodern thought is therefore also reflected in the study design.

Furthermore, postmodernism has opened the world of healthcare and science for arts, allowing them to be widely present in diverse contexts (Karkou et al. 2011: 2) and is therefore seen by the researcher as most relevant to the field of arts therapies in general.

3.2.2 Mixed methodology and mixed methods

In order to address complexity of the main research questions and suggest solutions, this study drew upon both qualitative and quantitative paradigms and employed mixed methodology. In mixed methodology research “qualitative and quantitative approaches are used in types of questions, research methods, data collection and analysis procedures, and/or inferences” (Tashakkori & Teddlie 2003: 731). Mixed methods research allows, therefore, for expanded understanding of the problem explored. As

summarized by Creswell (2009: 203), “there is more insight to be gained from the combination of both qualitative and quantitative research than either form by itself”; and it has been important for the researcher to design a study which would, at the very least, attempt to offer opportunities for gaining diverse insights, in both research and therapeutic sense.

Sequential and concurrent mixed methodologies procedures have been combined in this research. The whole study consisted of two phases and mixed methods were used within each. In the first stage quantitative and qualitative data collection (survey) had been complemented by an additional survey (qualitative only) and both data sets were analysed jointly. Once phase one had been completed (data collected and analysed), phase two of the study followed, in which more quantitative data were collected (pilot pre, post and follow up test study) with embedded qualitative datasets (interviews, participant observation and researcher’s arts-based reflection). Again, the two sets of data were interpreted. The final analysis looked at both phases of the study and conclusions were drawn from all the results.

While the general initial design of this research, as summarised above, has been followed throughout the three year long project, there has been a shift in the weight of quantitative and qualitative data. In the very early ideas of the study design quantitative data were highlighted as carrying more weight and substance with supportive qualitative data embedded in the primarily quantitative design.

During the research process and even more in the phase of data analysis it became apparent that the richness of qualitative data offers information of an importance not previously anticipated. At the same time, challenges around undertaking the pilot clinical study did not offer opportunities for statistical analysis as substantial as planned. Those two unexpected effects led to the shift in thinking about the distribution of weight from different data sources in this project. While both paradigms remain equally important for this research on a philosophical level, the qualitative data now carries more weight than anticipated, especially in phase two of the project. The described shift of weight immediately followed the developing knowledge and may be considered as an evidence of a flexibility of the research design and its willingness to adapt to changing circumstances, in line with pragmatism and intention to represent a real life research instead of creating purely experimental conditions.

The visual model below (Figure 2) illustrates the final study design using common in mixed methods research notation (Creswell 2009: 209) for indication of actual distribution of weight in qualitative and quantitative data.



Figure 2: Visual model of the study design: quantitative and qualitative components.

In phase 1 both sets of data carry equal weight and complement each other to offer understanding as broad as possible. In phase 2 rich qualitative data is collected within a pilot study of a primarily quantitative design.

The complexity of the study design reflects the notion that research is not always linear but rather a “set of interactive components” (Creswell 2010). In the current study the respective qualitative and quantitative elements appear on the research scene at various points in time and remain in constant dialogue with each other to become eventually integrated towards the end of the project.

Figure 3 illustrates interaction between various components of this research and indicates multiple data integration procedures, as specified by Creswell et al. (2010). Merging of data in phase 1 happens during simultaneous analysis of the three datasets. Connection of data between the two phases is enabled when findings from phase 1 inform development of intervention to be used in phase 2. Embedding of data is utilised in phase 2 where qualitative data collection is nested within the generally quantitative design of a pilot pre, post and follow-up test study. Finally, the findings originating in multimodal sources of phase 2 are integrated to offer a consistent understanding of the studied phenomenon.

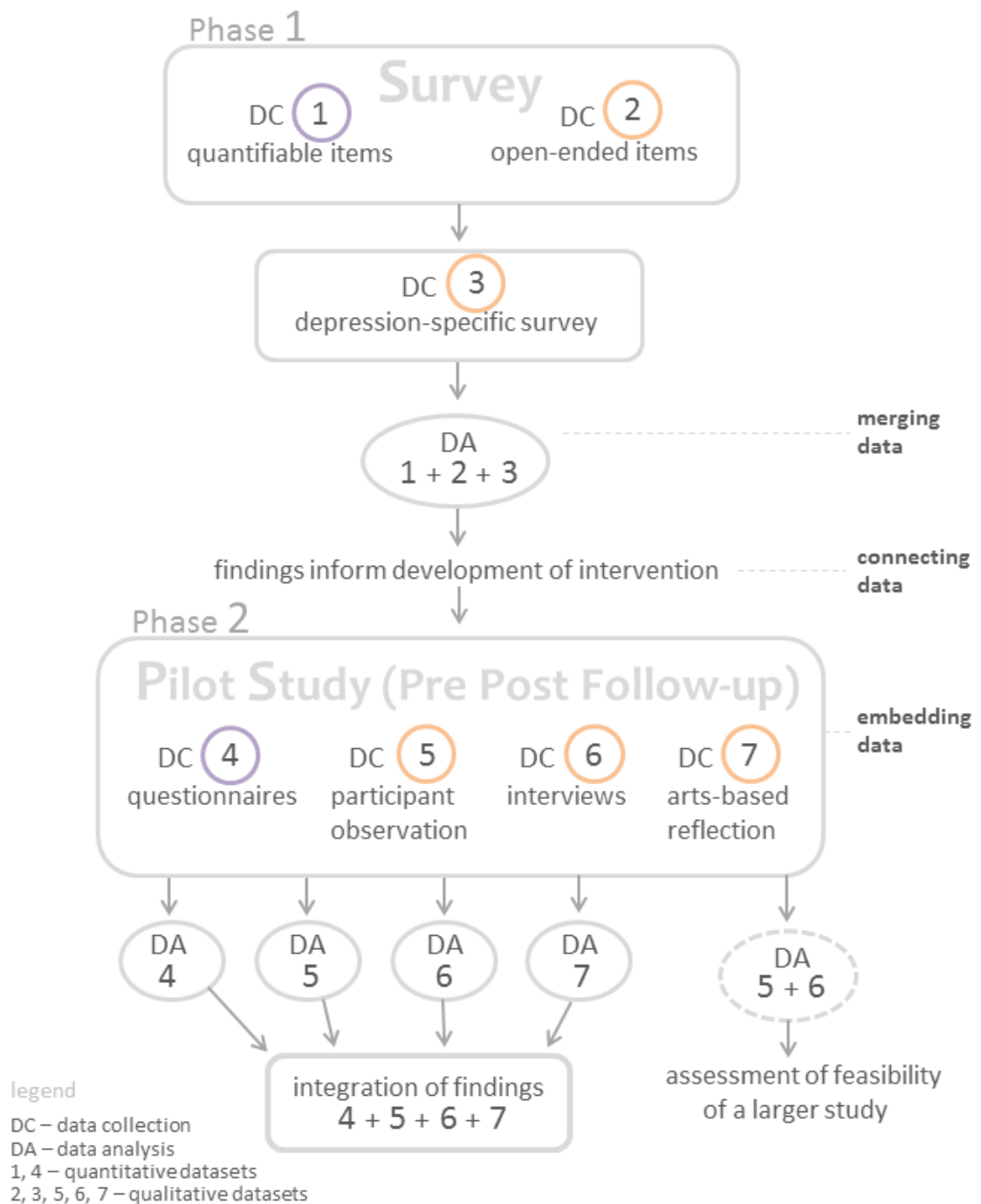


Figure 3: Interaction between the components of the study and methods of integration.

In a brief summary, this is a mixed methodologies research study with quantitative components and added value of qualitative data to broaden the perspective and to deepen the understanding by multi-dimensional approach to data collection and analysis.

3.2.3 Justification of the study design

The designing of this study was a creative process in itself, which corresponds well with the subject of this research. The value of similar creative approaches to research has been noted by McNiff (2007).

As mentioned above, mixed methodology and methods seem to be especially appropriate in arts therapies research. While evidence is needed and numerical results are required to establish the evidence of arts therapies as treatment solutions, qualitative data are often essential for clinical practice and more meaningful to most therapists. Many of them value clients' experiences and the process of therapy over numbers resulting from psychometric scales. There has been a common argument among arts therapists, who believe that outcome measures do not reflect subtle changes or improvements, which can only be noted by using qualitative methods (Gilroy 2006; Payne 1993).

However, it is recognised that certain standards need to be developed for every therapy and treatment addressed to humans. In a world where evidence based practice (EBP) is expected of all health practitioners, including arts therapists, and where evidence is often associated with the results from rigorous quantitative research designs such as randomised controlled trials, quantitative methods need to be given more credit in arts therapies research. It is most important to use them in conjunction with other methods (Gilroy 2006) and creatively (Meldrum 1999; Meekums 1996). Only then may evidence be provided and gain deeper sense, when the core of all arts therapies is preserved: orientation on human and inner experience.

In addition, having stemmed from previously mentioned philosophies, this research study strived for a desired balance in all of its aspects: methods and the study design thus reflect the focus on human experience and creativity, while leading to meaningful conclusions for not only arts therapists themselves, but also other professional environments and, most importantly, the people suffering from depression. Such eclectic and imaginative approach to research accommodates both numerical data and verbal accounts, experience and creativity, giving a comprehensive and honest picture, unbiased by a single method or procedure and thus potentially meaningful to a wide and diverse audience.

In designing this multimodal research it seemed particularly important to include arts-based elements (McNiff 2007) among its components as it is believed that “using images can facilitate or encourage a certain transparency, introducing the potential for reflexivity into the research design” (Weber 2008: 46).

Kossak (2012: 24) notices:

“If those in the field of art-based enquiry shy away from art-based methods in research, then there is danger of falling into the trap of conceding to the prevailing authority at the risk of losing the essence of what the field has been built upon.”

Haywood Rolling (2010: 105) even states, quite controversially: “the arts and sciences are twin peaks in human cognition and neither should be privileged in research practices”. Thus, although constituting relatively minor part of the study elements, arts-based reflection is believed to have made a meaningful addition to this comprehensive inquiry. The table below (Figure 4), adapted from Leavy (2009: 257), presents some of the features of quantitative, qualitative and arts-based research, which in fact do not contradict but rather complement each other. By addressing all the mentioned areas, this research hoped to offer as holistic picture of arts therapies for depression as was possible within its scope.

Quantitative	Traditional qualitative	Arts-based qualitative
Numbers	Words	Images
Measurement	Meaning	Evocation
Reliability	Process	Authenticity
Validity	Interpretation	Truthfulness
Disciplinary	Interdisciplinary	Transdisciplinary

Figure 4: Features of quantitative, traditional qualitative and arts-based qualitative inquiry. (adapted from Leavy 2009)

In addition to previously mentioned relevance to the studied subject, mixed methodologies also offered an opportunity for strengthening the scientific value of the inquiry. Data collection from various sources and using diverse methods ensure that the principle of triangulation is met. In this particular project the datasets are: a) complementing each other (e.g. QUAN and qual in Phase 1), b) expanding the scope of

the study (e.g. QUAL nested in qual in Phase 2), c) informing each other (e.g. intervention in Phase 2 informed by data from Phase 1). Multiple interactions of datasets require constant reflexivity (Tashakkori & Teddlie 1998) from the researcher, but ensure that no single perspective is given priority over others. Integration of datasets and methods is attempted in the final stages of analysis and presented in chapter 5 (Core discussion).

On a final note, it is hoped that the combination of methodologies and methods resulted in a design which is complex yet relevant to the concepts studied. May the comment made by Frankel (1999: 346) further explain: “The only limitations that exist to doing creative integrative research that explores new territories and horizons are those that are self-imposed.”

Due to the complexity of this research, its two phases will now be presented separately with the focus on purpose, participants and procedures implemented in each phase.

3.3 Phase 1: Description of arts therapies practice with depression

3.3.1 Purpose

Phase 1 of this research aimed to provide a description of arts therapists’ work with depression and to identify the patterns emerging from their practice, by responding to the following research question:

- How do arts therapists in the UK work with adults faced with depression?

It also aimed to collect and process information, which could later be used for the development of a suitable treatment protocol in phase 2 of this research (planned to be informed by the results from phase 1).

In order to provide comprehensive description of arts therapies practice, more specific objectives corresponding to certain aspects of clinical practice were identified and included finding answers to the following questions:

- Do arts therapists work with depression? What is the extent of this work?
- How do arts therapists understand the nature of depression?
- What theoretical backgrounds determine arts therapists' practice with depression?
- What are the characteristics of the therapists who work with depression? Do they differ from the characteristics of those, who do not work with depression?
- What does the practice of arts therapists with depression look like? What elements of therapeutic process, tools and interventions are commonly used?
- Does the practice of arts therapists, who work with depression, differ from the practice of those, who do not work with depression? If so, in what area(s)?
- In what areas, according to the experience of therapists, may arts therapies be beneficial to those, who suffer from depression?

3.3.2 Procedure: surveys

To best address the aims of phase 1 of this research, a nationwide survey, interested in practical and professional aspects of arts therapists practice, including theoretical principles, aims, methodology and evaluation, was conducted. This survey was delivered to participants electronically and was launched in June 2011 and closed in September 2011. An additional survey was conducted in the following months with aim to enhance understanding of clinical practice of those arts therapists, who specialise in working with depression.

3.3.3 Participants: arts therapists

Phase 1 of this research included arts therapists who were qualified to practise within the UK (having completed relevant training at postgraduate level, either in the UK or overseas) and/or who acquired licence to practise as arts therapists from the relevant professional associations: British Association of Art Therapists (BAAT), Association for

Dance Movement Psychotherapy UK (ADMP UK), British Association of Dramatherapists (BADth) or British Association for Music Therapy (BAMT).

The survey was intended to reach all arts therapists registered in the UK. The estimated number of therapists in 2011 was 3,000, according to Health Professions Council (HPC)'s (currently Health & Care Professions Council, HCPC) statistics for which three out of the four of the arts therapies were registered with (at the time of the survey, dance movement psychotherapists' registration with HPC was pending). As personal details of arts therapists could not be made available to the researcher (under Data Protection Act), support for the study was sought from Arts Therapies Professional Associations, who were first contacted in December 2010 and again in June 2011 with detailed information about this study (see Appendix 2).

Positive responses were received from all four Associations (BAAT, ADMP UK, BAMT and BADth) and help with advertising of the survey was offered. Three of the Associations responded that their policy did not allow them to circulate e-mails to members, but all Associations agreed to include an advert with the web link to the survey (see Appendices 8 & 9) in e-Bulletins and newsletters. ADMP UK included information about the survey on members' website and in e-Motion journal, published by the Association quarterly. Relevant information was also included in the 'News' section on BAAT website. (See Appendix 3 for detailed information on the process of advertising.)

Other associations and networking groups contacted and willing to help with dissemination of the survey included: The Scottish Arts Therapies Forum (SATF), Northern Ireland Group for Art as Therapy (NIGAT), Nordoff-Robbins Music Therapy and London Arts in Health Forum. The survey was also advertised via e-mail in some of the arts therapies clinical settings. In August 2011, programme leaders of arts therapies courses in Higher Education Institutions in the UK were contacted and asked for assistance in forwarding invitation e-mail to colleagues and graduates. In addition, the researcher advertised the survey through personal contacts with arts therapists.

Exact number of arts therapists who received invitation to the survey cannot be known and although efforts were made to reach all arts therapists practicing in UK, the actual number of potential participants contacted is most likely much smaller. Cook et al. (2000) suggest that number of pre-contacts and reminders are the factors associated

with higher response rate in online surveys (p.833) while Kaplowitz et al. (2004) report positive effect of surface mail pre-notices and reminders. In this study the researcher could not have a direct control on the advertising process and her role had to be limited to contacting Associations. Thus, reminders could not have been sent regularly and the advertising had to rely on the Associations' regular way of contacting their members. As e-Bulletins and newsletters require additional subscription, some (or possibly most) of the arts therapists do not receive them and therefore had less chance to get to know about the research. This has been identified as the most significant limitation of this phase of the research (see section 3.5).

3.3.4 Methods

3.3.4.1 Method 1: Main questionnaire (quantitative and qualitative items)

The questionnaire used in the current study was developed by Karkou in 1996 (Karkou & Sanderson 2006) and revised in 2009. It consisted of multiple choice, single choice and open type questions, concerning: general information about practice (8 items), theoretical influences (2 items), assessment and evaluation (4 items) and biographical information (6 items). Items concerning theoretical principles (37 in total) were grouped in six factors (labelled: Humanistic, Psychoanalytic/Psychodynamic, Developmental, Artistic/Creative, Active/Directive, Eclectic/Integrative). Between five and seven statements were allocated to each theoretical principle (factor) and required respondents to indicate their agreement or disagreement on a scale of 1 to 5. One example of statement for each factor is given in Figure 5 (for full list of items please see Appendix 1). The questionnaire also included several open-ended items, which allowed respondents to freely share their experience and opinions on theoretical influences, assessment and any other aspects of practice not mentioned in the survey.

The questionnaire was adapted to the purpose of this research in 2011 to include three additional items allowing for identification of arts therapists who worked primarily with clients/patients with depression. Also, an online version of the questionnaire was developed for the purpose of this study using Bristol Online Surveys system.

Humanistic	The purpose of the therapy has to do with the “wholeness”.
Psychoanalytic / Psychodynamic	Therapeutic change is facilitated by achieving insight.
Developmental	I am aware of the developmental stages my clients are at.
Artistic / Creative	I encourage clients to be as spontaneous as they possibly could be.
Active / Directive	I do have certain techniques that I bring out when it is appropriate.
Eclectic / Integrative	My ideas are designed in collaboration with the clients.

Figure 5: Examples of items from each of the six factors describing theoretical influences.

To ensure the quality of the questionnaire after those changes (additional items and new mode of delivery), it was firstly evaluated in a pilot among arts therapists at QMU: lecturers and postgraduate students (see Appendices 4 & 5), which took place in May/June 2011. All of the 29 participants accepted the online mode of delivery with majority of them clearly preferring this to the traditional paper mode. The structure, content and presentation of the questionnaire were generally positively evaluated. Respondents also provided other positive feedback including comments on the valuable opportunity to take time to think about their practice (see Appendix 6 for detailed evaluation of this pilot).

Online delivery of this survey was chosen for number of reasons, including cost, need of Associations’ assistance in distribution and creative openness of this research for making good use of technology for scientific purposes, wherever possible and justified. While it has been suggested that response rates for e-mail or online surveys may not equal those of more traditional methods (Cook et al. 2000), some studies show that the quality of answers to open-ended questions tends to be higher in electronic than in mail surveys (Yun and Trumbo 2000). Several items in the questionnaire allowed the participants to express their opinions and comments on their practice and this opportunity has been well received and used extensively, which will be further discussed in section 4.2.3.

3.3.4.2 Method 2: Depression-specific questionnaire (qualitative items)

Initially, semi-structured interviews with arts therapists were planned, which, due to time restrictions and encouragement gained from the success of the nationwide survey (with a good number of responses of high quality), took the form of a more detailed questionnaire with open-ended questions only, which was e-mailed immediately after the main survey closed to those participants, who worked specifically with depression and agreed to be contacted (see Appendix 10).

The short questionnaire was designed by the researcher, with aim to collect more detailed accounts from those therapists, who presumably have had the most expertise and experience in working with depressed adults. The questions were chosen to either deepen or complement the information received through the main survey. Among others, the participants were asked about:

- origins of their interest in working with people suffering from depression: *Why do you work with people suffering from depression? (eg. personal interest, motivation; nature/requirement of work setting)*
- challenges and rewards of this type of work: *Do you encounter any specific challenges while working with people with depression? Do you experience any particular rewards from working with people with depression? If so, what are they?*
- opinions on approaches and interventions they find particularly helpful in their work: *Are there any specific interventions and/or tools which you find most helpful and use most often in your practice? If so, what are they?*

(For a list of all questions and survey template please see Appendix 7.)

3.3.5 Data analysis

Data collected in the survey have been analysed using descriptive and inferential statistical methods (quantitative dataset) and thematic analysis (qualitative dataset). SPSS served as a tool for statistical analysis, while NVivo software proved helpful in organising and interpreting qualitative material.

3.3.5.1 Quantitative analysis

Initially, descriptive statistics were used to illustrate demographical data of arts therapists, who responded to the survey. Following that, groups of arts therapists who worked with depression, those who do not work with depression and those who specialise in working with this condition were identified and compared on various aspects of clinical practice. Z-test was used to illustrate the relation of prevalence of various styles of working, client groups, settings, etc. in different groups of therapists. T-test was employed on one occasion, where the data allowed, to compare groups of arts therapists on theoretical factors, on which they based their practice. Pearson Chi-Square test was used to further identify differences in theoretical influences between groups.

3.3.5.2 Qualitative analysis

a) subject of analysis

Qualitative analysis was performed on data collected from the respondents through four open-ended questions. Item 27c, included specifically for the purpose of this study, concerned work with depression in particular (see Appendix 1). Additional open-ended questions concentrated around theoretical influences (item 10) and assessment and evaluation (item 19). Respondents were also given an opportunity to provide any other comments, not further specified (item 20).

Eventually, analysis was performed on all responses given to item 27c (regardless of declaration as to frequency of work with depression) and on all other responses to open-ended questions given by those therapists, who work mainly with depression (group D+). Responses to open-ended questions other than 27c, given by arts therapists who either do not work with depression (D-) or for whom people with depression are not the main client group (D+/-) were not included in the analysis. Total number of responses analyzed was therefore 182 (126 responses to item 27c, 25 responses to item 10, 17 responses to item 19 and 14 responses to item 20). This way, only responses directly concerning depression were analysed and the findings genuinely illustrate

subjective opinions of those arts therapists, who have relevant experience and were willing to share their knowledge about this condition.

In order to further the understanding of arts therapists' work with depression, additional data was collected. As previously mentioned in section 3.3.4.2, the respondents in group D+ (working mainly with depression), who agreed to be contacted for more data collection, were emailed with invitation to complete an additional qualitative depression-specific questionnaire, designed by the researcher and asking for more detailed comments on their practice in the highlighted areas (see Appendix 7). A group of 38 respondents met the criteria (1 - work primarily with depression and 2 - agreement to be contacted) and were contacted. Seven therapists completed and returned the depression-specific questionnaire. It needs to be noted that for five of the seven respondents art therapy or art psychotherapy was the main therapy type they were using. The remaining two participants reported to have used mainly: systemic psychotherapy (combined with art therapy) and group analysis.

b) methods of analysis

All relevant responses had been carefully coded and numerous comparisons of single items eventually allowed for identification of meaningful themes and categories. Finally, consistent patterns of arts therapists' practice were revealed.

Thematic analysis (Vaismoradi et al. 2013, Braun & Clarke 2006) served as a general framework for approaching qualitative data. Search for consistent themes emerging from datasets was in focus at all times while the process of coding could most accurately be described by the method of template analysis, a variation of thematic analysis, where a "template" is created, "which summarises themes identified by the researcher as important in a data set, and organises them in a meaningful and useful manner" (King 2011). The template can originate "a priori" from theory and knowledge, or may emerge from the process of coding. An intermediate approach is common, where "some initial codes are refined and modified during the analysis process" (Crabtree & Miller 1999: 167).

In case of this research, the dataset was initially approached by the researcher with no preconceptions and with intention for the codes to naturally emerge from the raw data.

This method was successfully employed to certain stage, after which a specific clusters of codes started to form meaningful and repeating themes. Therefore, further coding allowed for both: creating new codes and adding items to codes already identified. This flexible approach allowed for appreciation of the knowledge already existing in the field of arts therapies and for openness to new ideas. At certain points, elements of quasi-statistics (Becker 1997) were used, when occurrences of certain items were counted (e.g. underlying psychological problems in depression, see section 4.2.3.3.2).

The analysis was performed through careful and systematic coding using NVivo9 software. It is important to note that all questions to be analysed were intentionally kept as open as possible, using the following format: “Please share any further comments on [theoretical influences /evaluation /work with depression]”. Therefore, nearly no preconceptions on the researcher’s side were present and open coding was applied to all responses in order to identify subjects, which seemed of particular significance to arts therapists. However, certain themes (e.g. Theoretical influences and Assessment and evaluation) have simultaneously emerged as a more direct response to the questions. Therefore, the framework of template analysis proved helpful in combining codes of these two different origins. As a result, themes were identified and grouped into categories to provide meaningful structure to the analyzed data.

In analysing data derived from the depression-specific questionnaire most codes originated from the actual items included in this questionnaire. Relationships between the codes became significantly important in analysing material concerning aims and tools used by therapists in their practice (see section 4.2.3.5.3).

3.3.6 Ethical approval

A full ethical approval for conducting phase 1 of this research was granted by the Queen Margaret Research Ethics Committee in May 2011 (see Appendix 13).

3.4 Phase 2: Evaluation of arts therapies practice with depression

3.4.1 Purpose

Phase 2 of this research aimed to provide answer to the following core question:

- What is the value of arts therapies in the treatment of depression?

In the planned evaluation primarily quantitative approach seemed initially most suitable. However, while it became apparent that qualitative data may in fact hold a special clinical value, they were eventually given a more pronounced position in the mixed methodology design (see section 3.2.2). Such approach seemed most appropriate given the current state of research in arts therapies and a growing need for quality exploratory studies to enable further assessment of effectiveness (see section 2.3.5). Therefore, a pilot study (Thabane et al. 2010, Lancaster et al. 2004), aiming to assess the feasibility of a larger randomised controlled trial was conducted.

According to Thabane et al. (2010), a pilot study should not aim for a large sample and statistical power, but rather concentrate on providing the best possible base for a future research. Evaluation of arts therapies and assessment of feasibility for a larger RCT were therefore in the focus of this phase of the study. Assessment of effectiveness or results of a statistical significance were not among the aims, as were not achievable within the set boundaries of time, budget and expertise. Instead, all efforts have been made to ensure that a sound basis for further research is created.

The core research question demanded addressing more specific objectives, which were grouped into two main areas, concerning: 1) evaluation of arts therapies for depression and 2) assessment of feasibility of a larger study. These objectives were as follows:

1. Evaluation of group arts therapies for depression

- to identify any changes in depression levels / depressive symptoms – primary outcome (measurement based on PHQ-9)
- to identify any changes in anxiety levels and satisfaction with life – secondary outcomes (measurement based on GAD-7 and WHO-5)

- to collect participants' evaluation of the experience of arts therapies (based on direct accounts from participants collected in final and follow up interviews)
- to explore significant moments and themes in arts therapies process (based on observation of the group sessions and arts-based active reflection)

2. Assessment of feasibility of a larger randomised controlled trial to measure the effectiveness of arts therapies in the treatment of depression

- to assess recruitment potential via voluntary organisations, advertising within NHS and self-referring in response to Internet publicity
- to assess retention rates (attendance, compliance and completion rates)
- to assess appropriateness of eligibility criteria
- to assess resources (time needed to complete interviews, questionnaires, etc.; spaces and locations most suitable for group arts therapies; capacity and willingness of voluntary organisations and the NHS to participate; budget needed to complete the future study/ies)
- to assess safety and acceptability of the intervention
- to increase clinical experience with the intervention
- to estimation treatment effects and confidence intervals (if possible)

Complexity of objectives in phase 2 of this research required flexible and creative approaches to the research design, data collection and analysis methods. A presentation of the procedure and methods in as clear as possible manner will now be attempted.

3.4.2 Procedure: pilot single group pretest, posttest, follow-up study

Ideally, a pilot small scale randomised clinical trial would have been undertaken in this part of the research. However, due to limitations further discussed (see section 3.5), this initial idea needed to be adapted to what was realistically possible in the given timescale and with available resources. Inability to recruit enough participants to form a control group in the given timeframe, limited by the lengthy process of obtaining necessary ethical approvals, meant that an RCT could not be attempted. In addition, difficulties with facilitating two arts therapies groups as originally planned (see next section) led to

limitation of this project to evaluation of one of four arts therapies. In effect, a pilot single group study of a pretest, posttest and follow-up design was conducted.

3.4.2.1 Type of therapy and participants (overview)

In the pilot an art therapy group treatment for adults suffering from depression was facilitated. Although it would have been ideal to pilot all four arts therapies, it was decided within the research team that facilitating two arts therapies groups would be more realistic, considering the limitations of resources. It was agreed that art psychotherapy and dance movement psychotherapy would be evaluated, as other disciplines of arts therapies have either provided some evidence of effectiveness already (music therapy) or have not yet built research base rich enough to provide suitable scientific background (dramatherapy). Moreover, specific expertise of the research team lay within dance movement psychotherapy and art psychotherapy. Unfortunately, this plan required further adaptations due to unforeseen challenges. No availability of dance movement psychotherapists working within NHS Lothian and no acceptance from the University for a trainee therapist to facilitate a group in this project meant that a decision needed to be made to offer art therapy only and limit the study to a single group design.

Number of between 5 and 8 participants in a group was agreed on, as the most optimal for a psychotherapy group (Bateman 2010, 162). It was initially hoped that a control group of size corresponding to the size of a treatment group would also be formed and offered participation in arts therapy after the study had finished. This plan needed to be reassessed with regret and the study limited to a single treatment group only.

Several reasons prevented this project from including a control group and these included: 1) time restrictions during recruitment, which needed to be significantly limited due to unexpectedly lengthy process of obtaining approvals from the NHS and 2) financial restrictions not allowing payments for the therapists in this project under the rules of the researcher's bursary contract. The first reason meant that not enough participants could have been recruited in the remaining time. The second reason meant that offering post research treatment to a control group could potentially not be made possible. Lack of certain number of participants as a pragmatic reason and uncertainty

of treatment availability as ethical reasons were each considered significant enough to divert from initial plan and limit the study to a single group design. Comprehensive discussion of limitations in this phase of the research and its evaluation will be offered in section 4.4.

Eventually, this study included 5 participants. It is understood that such small sample does not allow for a significant effect and power calculations for future studies. However, the number is believed to be sufficient, while the aim of this study is to determine trends rather than effects, and to assess feasibility, as explained above. The participants' response to therapy was evaluated using a battery of questionnaires as well as interviews and observation (for further details see sections 3.4.4 & 3.4.5).

Phase 2 of this research had been shaped by the data collected from arts therapists through the questionnaires and the full protocol for the presented pilot study reflected the findings from phase 1 (phase 2 of the study is sequential to phase 1 – see section 3.2.2). However, due to the complexity of the pilot itself, preparation for phase 2 had begun much earlier, in the background of phase 1, including arrangements for participants' recruitment and standardization of treatment in line with current guidelines for depression (e.g. Jongsma et al. 2006). Production of the treatment manual for the intervention was a lengthy process in itself, further discussed in section 4.2.4.2.

3.4.2.2 Therapist

A local qualified art therapist with special interest in depression volunteered to deliver group therapy in this project. The therapist offered her time to meet with the researcher on two occasions before the start of the treatment and shared valuable comments on the emerging treatment manual. Time was allocated before and after each session for the therapist and the researcher to consult the progress and share insights and suggestions for further intervention. Thus, it needs to be acknowledged that the actual intervention was shaped by both the treatment manual and the therapist's experience.

3.4.2.3 Length of therapy

The participants attended group art psychotherapy sessions. The duration of the treatment was initially planned for 12 weeks to allow time for a deeper therapeutic process to take place. This length of therapeutic intervention has also been used in other research studies that evaluated arts therapies through an RCT design worldwide (Jeong et al. 2005; Hamamci 2006). However, recent trends in arts therapies RCT-based research seem to support the tendency to shorten the total time of treatment, while intensifying it by providing therapeutic sessions more often than once a week (Castillo-Perez 2010; Erkkila 2011) in order to offer best possible treatment to patients/clients. A similar approach was eventually adopted in this study, where art psychotherapy was offered to participants twice a week, over 5 weeks (9 sessions in total).

3.4.2.4 Setting

The groups were initially intended to take place at the premises of one or more voluntary organizations, aiming to support people experiencing mental health problems. Several charity organizations which were contacted during the months preceding the project, expressed their interest in the study and willingness to both provide space for groups and assist in the recruitment process. However, it became apparent that the willingness to support this study in most cases did not correspond to the capacity to host the research, as practical considerations made it unrealistic to deliver arts therapies groups. Some of the charities did not consider their clients suitable for the study, while others, being busy day centres, could not afford to provide rooms free of charge. The possibility of renting suitable spaces within the community was also considered.

Finally, suitable premises for conducting initial interviews with participants and the treatment were sought within NHS health setting, as it became especially important for the researcher to conduct initial interviews with self-referring participants within professionally staffed premises, where support would be available, if needed. A local mental health hospital (Edinburgh Royal Hospital) was identified as a safe and most appropriate place for both: interviews and facilitation of treatment. Office spaces for conducting interviews were available within an Outpatient Unit while an art room in the Occupational Therapy department provided a very suitable space for the treatment.

3.4.2.5 Ethical approval

Once management approvals were obtained, an ethical approval was sought from the local NHS Research Ethics Committee and the NHS Research and Development Team. Gaining ethical approval for this research from the NHS proved to have been a difficult and lengthy process, which took six months of year 2012 and further two months of year 2013. Following two sets of requested amendments (see Appendices 14 & 15), the final ethical approval was obtained from the local Research Ethics Committee and the Research and Development Office in September 2012 (see Appendices 16 & 17). An Honorary Research Contract, enabling the researcher to access NHS premises for the purpose of the project, was obtained in February 2013 (see Appendix 18). Further details on the process of obtaining all necessary approvals may be found in section 4.4.4.1.

3.4.3 Participants: adults suffering from depression

3.4.3.1 Eligibility criteria

This pilot study looked to recruit participants who: a) are adults (age between 16 and 65), b) currently suffer from mild to moderate depression (based on self-disclosure and assessed through completion of PHQ-9), c) are willing not to engage in any other, new to them, psychotherapeutic treatments during the course of the study.

Exclusion criteria applied to those a) who were not able to give an informed consent, b) whose English was not fluent enough to communicate meaningfully, c) who suffered from any mental health condition with psychotic component (based on self-disclosure and observation), d) whose severity of depression might have affected their ability to complete required questionnaires and might have significantly lowered the likelihood of regular attendance.

If the study was to be conducted with participation of patients using NHS services for their mental health condition, participants with co-morbid mental health diagnoses (e.g. psychotic symptoms, personality disorders, substance abuse) could be easily excluded to ensure better control of variables. However, as the participants were recruited from the community and not via health professionals, their formal diagnoses could not be

confirmed. This study, being a 'real life' research accepted that the participants were recruited based on what they disclosed during the initial interview with the researcher, whose qualification in clinical psychology proved especially helpful in the first contact and assessment. Moreover, one of the researcher's Supervisors, who is a consultant psychiatrist, offered every support and guidance in the process. A valid and reliable scale (PHQ-9) offered an additional tool for assessment of the extent of potential participants' depression (see Appendix 19 and section 3.4.4). For more details on evaluation of the process of diagnosis in this project please see section 4.4.3.

In line with the intention-to-treat principle, it was accepted that the participants were treated as they would normally be in the NHS health care system while attending arts therapies groups. It was therefore understood that some or all of them might have been receiving pharmacotherapy and/or counselling sessions while in arts therapy groups. Participants were, however, advised not to engage in a new to them form of psychotherapy for the duration of the study, unless they have already been in a long term therapy before the study has started.

While inability to implement tight inclusion criteria might be perceived as limitation of this study, such strategy fits well within its philosophical foundations that the research should not adjust external conditions, but rather adapt itself to reflect the organic nature of the world and especially human experiences. Thus, this project did not aim for a pure and fully homogeneous sample, but rather to identify a group of participants, who would represent well the population of depression sufferers. It should be noted, that while such approach is seen by the researcher as acceptable, if not desirable, in a pilot study, it most likely would not be appropriate for a larger pilot study or an RCT, where an increased control of variables would be advisable (section 4.4.3 offers further suggestions on this matter).

3.4.3.2 Recruitment process

Participants in the study were recruited from the community, through voluntary organisations and self-referred in response to Internet and direct advertising, including leaflets and posters distributed locally. Preparation for the recruitment started well in advance of the project and involved: (1) compiling a list of email and postal addresses of

services, institutions and community spaces where adverts could be placed or sent to, (2) organising access to an office space within the Hospital for initial meetings with potential participants, (3) producing adverts in paper and electronic formats.

In a summary, recruitment actions included:

- a) advertisement on mental health organizations' websites
- b) advertisement in newsletters, bulletins and premises of: local mental health services, community centres, student counselling services, private sector services
- c) advertisement in local NHS premises, including GP services and Community Mental Health Teams, in form of posters and flyers

Various mental health charities expressed their willingness to advertise this research among their clients and collaboration with two organisations has been agreed: Action on Depression (then Depression Alliance Scotland) and Health in Mind. Action on Depression is a Scottish charity, providing support to individuals affected by depression – both in the community and online. They could not offer rooms to be used for the purpose of this study, only using modest premises as office and meeting space, but agreed to advertise the study online to promote recruitment. Health in Mind, a charity providing support to people experiencing various mental health problems, including depression, agreed to actively advertise this research among their service users from a mental health support project in Edinburgh, the SEASONS.

Other mental health services and community support groups have been contacted (a total of around 60), of which some expressed specific interest in advertising and promoting the project (e.g. Change Hoarding Action Group Edinburgh, Postnatal Depression Service).

Information about the research was also distributed (in a form of leaflets and posters) in nine GP practices in central Edinburgh, three Community Mental Health Teams, four community centres, student counselling services at three universities and a selection of several private services focusing on wellbeing and health.

3.4.3.3 Advertising materials

Various advertising materials were created by the researcher for the purpose of this project. Posters and flyers (Appendix 22) included basic information about this study, the researcher's contact details and a weblink to the website (Appendix 23) dedicated to this research and containing more details (<http://tinyurl.com/ArtsTherapiesResearch>). The website was intended to act as a more visually engaging and accessible information sheet, including details on what is expected from the participants, how they could benefit from taking part and what the risks were. It also allowed them to download pdf versions of both information sheet and consent form. This ensured that potential participants could be given enough time to reflect on the project and its possible implications before making an informed decision to take part. An electronic version of a flyer was used for dissemination through e-mails and for embedding in relevant websites.

Advertising of the project lasted for just over two weeks (started on the 29th January, with last adverts placed on the 8th February, and continued until the 15th February 2013). Adverts were sent by e-mail to local mental health services, networking and peer support groups (over 60 e-mails sent) and were placed in the form of posters and flyers in GP practices, CAMH services, community centres and university counselling services (28 places visited). Twelve potential participants (or their relatives) contacted the researcher during the two weeks of advertising. (It should be noted that further contacts continued in the following weeks.)

3.4.4 Quantitative methods: Questionnaires

In this research assessment of the severity of depression was considered a primary outcome measure, while the assessment of the levels of anxiety and general wellbeing constituted secondary outcome measures. Only other quantifiable data obtained from participants included age and gender, which, however, will only partially be disclosed in the results to ensure complete anonymity to participants.

Participants were asked to complete three questionnaires (PHQ-9, GAD-7 and WHO-5) on three occasions: before the treatment (week 0), after the treatment (week 5) and

during a follow-up (week 16-17). The PHQ-9 was additionally filled in by each participant in the middle of the treatment (week 3). The researcher arranged to meet with the participants for collection of these data. Initial interview was offered immediately after a potential participant stated that she/he was willing to take part in this project and the earliest convenient date was agreed on each occasion. Final interviews were arranged for the second day after the last (9th) session. Follow-up interviews were arranged individually in weeks 16 and 17 from the start of the project (11-12 weeks after the therapy).

It was believed that the combination of the aforementioned self-reported scales would provide a relatively comprehensive picture of various aspects of depression and their relation to the intervention of arts therapies, while not being too overwhelming for the participants. Achieving the balance between potentially available new knowledge (research value) and the participants' comfort was particularly important for the researcher during the process of designing of this study. For a more detailed evaluation of the presented methods and processes please see section 4.4.4.4. The mentioned questionnaires will now be briefly described.

3.4.4.1 PHQ-9: Depression

Severity of depression, a primary outcome measure, was assessed through **PHQ-9** questionnaire, a short scale widely used within the NHS and charity settings around the UK. It incorporates DMS diagnostic criteria and has proved to be a valid and reliable tool, which correlates highly with other commonly used measures like BDI-II or HAD-D (AHS University of Aberdeen 2011). In addition to being sensitive to change and therefore suitable to assess changes in depression levels over time, the scale is used as a screening and monitoring tool and served all of these purposes in this project.

3.4.4.2 GAD-7: Anxiety

Levels of general anxiety were measured using **GAD-7** (Spitzer et al. 2006) - a short scale, designed as a screening and diagnostic tool for a range of anxiety disorders (see Appendix 20). It has been frequently applied as a secondary outcome measure in depression trials alongside PHQ-9 (Instruction Manual for PHQ and GAD-7 2012).

3.4.4.3 WHO-5: Wellbeing

General wellbeing was assessed based on World Health Organization's **WHO-5** Well-being Index (see Appendix 21) - a short (5-item) scale consisting of positively constructed statements. It was developed in the 1990s by WHO's Psychiatric Research Unit (WHO-5, online) to assess subjective quality of life as a dimension of psychological wellbeing. Items in this scale relate to positive mood, vitality and interest in things as opposed to symptoms of ill-health or disability. The scale has been successfully used as a screening tool for depression (Primack 2003) in various client groups, is a valid non-invasive method to assess psychological wellbeing and presents a valuable addition to the measurement of depression itself.

3.4.5 Qualitative methods: interviews, observation and arts-based reflection

Not only did this research aim to evaluate arts therapies for their ability to alleviate symptoms of depression, but its equally, or possibly more important role was to focus on participants' experiences. Therefore, collection of qualitative data was embedded in the study design, using a general quantitative frame. Weight of collected data eventually enabled comprehensive exploration of all research objectives. While evaluation itself suggests numerical results, it seemed obvious to the researcher that the value of qualitative data should not be disregarded and is most likely to add another dimension and more clinical meaning to this research. Therefore, important secondary outcomes included: a) participants' evaluation of the experience of arts therapies and b) identification of significant moments in therapy.

The collection of the qualitative data took place simultaneously to the process of obtaining numerical data and it was expected that the outcomes of these different methods would complement each other, allowing for a true insight into arts therapies' realm. To use the words of Creswell & Garrett (2008: 328), this study has seen "qualitative data flowing into an otherwise quantitative intervention trial before the treatment, while the treatment is being conducted, (and) after the treatment".

Material for qualitative analysis was derived from several data sources including: 1) semi-structured interviews with the participants, 2) participant observation and 3) researcher's arts-based reflections following the sessions.

It needs to be noted that the interviews had dual role and intended to enable collection of data (research purpose) as well as psychological assessment (clinical purpose). Similarly, participant observation focused on both quite different components of this phase of the research (see section 3.4.1) and the qualitative data collected needed to reflect the two aims: assessment of outcomes of therapy and assessment of feasibility of a larger study. Collection of data for these two purposes was happening simultaneously, as it could not in practice be separated not to violate the therapy process. Themes relating to assessment of feasibility were extracted from the data in the process of analysis and will be presented separately (see section 4.4).

3.4.5.1 Interviews

Interviews with the participants were conducted by the researcher prior to and after the treatment, as well as during the follow-up. Their main purpose was to collect direct accounts from the participants of their expectations and experiences of arts therapies (see Appendix 24 for interview schedule).

Initial interviews were arranged as soon as potential participant contacted the researcher with willingness to join this second phase of the study. Importantly, this initial contact offered a space to clarify any concerns potential participants could have before signing the consent form. It also allowed for a more personal welcoming of the participants to the study – an aspect much valued by the researcher and appreciated by those who participated. Initial interviews took place at the Outpatient Unit of the Royal Edinburgh Hospital, lasted approximately an hour each and were recorded using a digital voice recorder.

Final interviews were arranged as soon as it was possible after the treatment has finished (on the second day after last session) and again voice recording was used. In addition to allowing for both quantitative and qualitative data collection, they served

the purpose of officially closing the treatment and offered the participants a chance to share any thoughts about the project or therapy which should not remain unspoken.

Eight weeks after their treatment finished, the participants were contacted by e-mail for the last time in order to arrange a follow-up meeting, for which they were again invited to the Hospital. The follow-up interviews happened between eleven and twelve weeks after the end of treatment. They were generally shorter than the previous interviews and were not recorded, but detailed notes were taken after each one of them. Follow-up interviews aimed to assess participants' mental wellbeing for the last time and to check whether there had been any new insights which they would like to share.

In final and follow-up interviews the participants were encouraged to share their experience of the treatment and current feelings. However, it was made clear to them that they were not expected to share any more information than they wanted to. This way, interviews remained an important continuation of the intervention providing opportunity for sharing final thoughts on the research and therapy processes.

3.4.5.2 Participant observation

The researcher was present in all nine therapy sessions and took notes, usually two to three pages of writing and graphs, immediately after the session finished (see Appendix 25 for observational notes template). During the time of intervention, she became an 'observer-as-participant' (Johnson and Christensen 2010: 209) and her primary role in group sessions was to observe actively while being useful to the group, offering additional support for the participants or technical help for the main facilitator, as and if needed. The researcher aimed to simultaneously immerse herself in the therapy process and to retain a desired degree of objectiveness. She recognised that both subjective and objective positions, which had already been embedded in the study design, would impact on data collection and analysis and aimed to employ reflexivity throughout the process.

It is important to note the researcher's physical position in therapy space: While the group was gathering in circle (at the beginning and towards the end of each session), the researcher was taking one of the places, alongside participants and the therapist.

While the group was engaging in art making (happening by a large table), the researcher was usually the last to take one of the available places at the table, alongside participants and the therapist. By physically positioning herself among the group members, the researcher was able to observe the therapy process closely, while avoiding taking unwanted role of observant, distanced from the group. It was assumed that observation from a specific position in the room, separate from the main action, might cause additional anxiety in the group and either prevent or instil emotions not necessarily helpful in a brief therapy process. It is, however, understood that the chosen approach might be criticised for a missed opportunity to increase objectivity of observation by removing oneself from the core action. While the researcher appreciates every need to apply as scientific methods as possible in any research, she made the decision to remain close to the group participants consciously, as she believed that such choice would increase chances of a truly honest therapy process to take place, while not compromising the research quality, but rather increasing it by an “insider’s” perspective, rarely available in psychotherapy research.

The participants seemed to accept the researcher as a “silent part of the group” and were aware of the very different roles of herself and the therapist. In order to minimise the impact of her presence on the therapy process, the researcher withstood from verbal comments during the discussion part of the sessions and limited her communication with participants to the minimum during the course of therapy. This included contacts during and outwith therapy times. Participants similarly made no attempts to verbally dialogue with the researcher during the sessions, although occasional non-verbal contacts were made, to similar extend to which participants made connections with each other and the therapist.

3.4.5.3 Arts-based reflection

In addition to recording notes in the journal, within few hours after each therapy session the researcher took time (usually half an hour up to one hour) to reflect on the therapy process, while immersing herself in thoughts about the themes which seemed significant in the particular session. Those reflections were arts-based (McNiff 2007; Simons & McCormack 2007) and inspired by the method of active imagination developed

by Carl Gustav Jung (Jung & Chodorow 1997) and the methodology of artistic inquiry (Hervey 2000), where, in a simplistic summary, a systematic immersion in artistic process eventually leads to new discoveries. In practice, on an evening following each session an image was created in a designated visual journal (see Appendix 30).

Kossak (2012: 22) explains: “Art-based research, a natural outgrowth of art-based enquiry, utilizes creative intelligence through immersion in creative process and scholarly reflection.” The method of active imagination (Jung & Chodorow 1997) aims to bring unconscious into consciousness through the channel of an art form. By interacting with images, “while maintaining waking level of consciousness” (Tomlinson 2011), the researcher may more clearly perceive ideas that are real and exist, but could have remained hidden if approached by other methods.

In the current study, arts-based data collection and analysis were hoped to provide a creative exploration of the therapeutic process and outcomes and allow for a deeper understanding of how the effects of arts therapies were achieved, if observed. The use of arts-based inquiry aimed to complete this creatively designed research and bring its understanding to a level not necessarily normally available to RCT studies.

3.4.6 Data analysis

Complex methods of data analysis were adopted to best interpret the diverse dataset and meet the objectives stated in section 3.4.1. Analysis of all quantitative (questionnaires) and qualitative material (interviews, observation, arts-based reflection) offered evaluation of a group art therapy for adults suffering from depression. Specific parts of the same datasets additionally enabled assessment of feasibility of a larger study. For the latter, qualitative data originating from interviews and participant observation were used. The process of analysis was carried with both aims in mind and simultaneously. In practice, in the process of analysis a separate category for assessment of feasibility was created where any suitable piece of information could have been placed. It needs to be noted that on occasions the same pieces of data were considered suitable for both: the evaluation and the assessment.

3.4.6.1 Quantitative analysis

Due to small sample and assumed lack of normal distribution, data collected through questionnaires were analysed using a non-parametric statistical test (a related samples Wilcoxon test) to allow for comparison of the results before and after the treatment. Specifically, comparisons were made between a) initial (pre-intervention) and final (immediately after intervention) results, b) initial and follow-up results, c) final and follow-up results. Statistical significance of any observed changes was assessed and areas of highest significance were highlighted.

3.4.6.2 Qualitative analysis

Qualitative analysis of datasets derived from various methods of data collection in Phase 2 of this research required approaches corresponding to the content (e.g. words vs. images) and nature of the data (e.g. responses to semi-structured interviews vs. unstructured reflections from observation). Methods of analysis of various datasets will now be presented in details.

a) Material from interviews

Qualitative data derived from interviews were approached using template analysis. The process was similar to the one described in section 3.3.5.2, where analysis of qualitative material in Phase 1 is discussed. NVivo software was used throughout the process of analysis to assist with data storage, coding and classification.

The content of initial, final and follow-up interviews was initially coded accordingly to categories devised from the questions. While specific themes were looked at within participants' responses, the method of template analysis allowed for unpredicted subjects to emerge. Both expected and emerging themes were then grouped into meaningful categories.

b) Material from observation

A set of ideas emerged from every session, uncovering the specific meaning of unique moments in therapy. Some of them appeared in more than one session, while others

found their place in single sessions never to be repeated. These ideas could range from totally abstract to tangibly concrete and originated from three sources:

1. the process of art making and artwork itself
2. the group discussion towards the end of each session
3. researcher's reflections after each session

The order of the sources is important, as most time was spent in art making process and this is when and where the first and most unconscious ideas emerged in every session. Group discussion, by bringing in a verbal perspective, often named those concepts, verified them and sometimes offered new ideas, inspired by what happened in the session. Eventually, the researcher's recording of notes after every session and simultaneous reflection on their meaning sometimes provoked additional ideas. These were added to the notes only when the author felt that the set was otherwise incomplete and when the new concepts seemed to be hidden behind the ideas emerging from artwork and/or those verbalised.

Notes from observation were organised in a table (see Appendix 29 for example) and later coded systematically. The process revealed repeating themes, which were named, listed and eventually placed on a matrix of sessions (see Figure 26 in section 4.3.3.1). This visual technique was adopted when it started to be clear to the researcher that certain themes were more likely to appear in particular sessions and change of themes throughout the course of therapy indicated the nature of the therapy process.

c) Material from artistic reflection

Apparent lack of scientific information on how to analyse data derived through arts-based inquiries (Colucci 2010) led to adopting the elements of the artistic inquiry methodology (Hervey 2000) and active imagination (Jung & Chodorow 1997) in approaching the created images. Following a period of "incubation" (Hervey 2000) of several months after they were created, a set of nine drawings were placed next to each other and the researcher immersed in silently studying their qualities for half an hour. Feelings and thoughts that emerged during this time, through the techniques of active imagination (Jung & Chodorow 1997), were immediately sketched or written down. They

provided a template and inspiration for creating a final image – an essence (Hervey 2000), which is the main finding, further commented on in section 4.3.2.2.2 and included as Appendix 31.

3.4.7 Ethical considerations and approvals

This study presented some challenging ethical issues, for which specific measures have been put in place to ensure participants' safety and wellbeing. Suitability of those measures was thoroughly assessed by the Research Ethics Committee at Queen Margaret University and the local NHS Research Ethics Committee, from which suitable ethical approval were obtained (see Appendices 13 and 16). A summary of main ethical issues will now be presented.

First of all, this study concerned vulnerable people – those experiencing mental health problems. Therefore, all the efforts had been made to ensure that sensitivity towards mental health issues was present within research team and its members were experienced professionals (movement psychotherapist, psychiatrist, psychologist), knowledgeable in the field. Consideration of participants' wellbeing was present throughout the process of designing the study and continued to be in place up until disseminating results. All members of the research team had a vast knowledge and years of experience in working with people affected by mental ill-health and one of the research supervisors in particular had specific knowledge and expertise in working with depression.

Secondly, the core of this research was providing art therapy, which, being a form of psychotherapy, had a potential to cause a degree of distress to the participants. It was considered likely that some or all of the participants would experience some psychological discomforts (e.g. increased worry, anxiety, feelings of guilt, anger etc.) during the course of the treatment. These were regarded as expected reactions to therapy, which should not last long and are often inseparable part of the process of transition and progress in psychotherapy. Participants were informed about the possibility of distress (please see Appendices 23 & 26) and all the efforts were made to ensure they received appropriate help through such moments. The presence of two

qualified and experienced professionals (arts therapist and researcher-psychologist) during therapy sessions aimed to ensure that the needs of individual participants could be met when required without compromising benefits of group work. Expertise of the supervisory team provided additional support and, should this have been needed, participant could have been referred to additional mental health service. One of the questionnaires intended as an outcome measure (PHQ9), also served the purpose of suicide risk assessment – its additional use to diagnosing depression (Simon et al. 2013). (This function of PHQ-9 has also been recognised by Action on Depression.)

Moreover, in respect for participants' choices, they were assured that they would not be left without treatment in case they did not agree to participate in the study or decided to withdraw from it. If they were service users of a mental health centre, they continued to receive support as they used to normally. If they contacted the researcher via the research website, they were still offered advice on who to contact in case they needed support but did not agree to take part in arts therapies.

Before giving their consent, potential participants were encouraged to ask questions, which were answered by the researcher through e-mail or telephone communication. The initial interview aimed to clarify any questions or concerns potential participants would still have. All the efforts were made to ensure that the participants gave a true informed consent (see Appendix 27) and understood what this research involved, what benefits it could bring and what the risks were. The researcher actively encouraged potential participants to rephrase and describe in their own words any areas identified as particularly complex.

Finally, confidentiality was ensured, both in the interviews and in group sessions. The participants were clearly informed about a non-judgemental approach to any of their responses or behaviours during the process of therapy and the completion of questionnaires. Participants were also given the right to withdraw from the study at any point without giving any reason. The researcher was available throughout the time of study for answering questions and clarifying concerns, whenever they appeared.

All of these arrangements were believed to have been adequate to reduce the risk of distress to the participants and ensure their wellbeing during and after the study.

3.5 Trustworthiness and limitations

Not free from challenges, this research strived for a balance between its inevitable limitations and actions undertaken to strengthen its trustworthiness. To ensure the highest possible methodological standard of the project, attention was given to various aspects of trustworthiness throughout the life of this research. In order to address the complexity of mixed methods study, two frameworks for ensuring trustworthiness were employed: 1) quantitative and 2) qualitative, based on criteria developed by Guba (1981) and Lincoln (1995).

Inclusion of multiple methods in this project was in itself a mean for increasing trustworthiness and transparency. Triangulation related not only to the data collection process but also to data analysis and further, where various ways of integrating findings allowed for multiple perspectives and multidimensional conclusions.

The following section will offer a description of how trustworthiness was further ensured and a presentation of some of the limitations to this research. For increased clarity two phases of the project will be reflected on separately.

3.5.1 Phase 1

3.5.1.1 Trustworthiness

This survey used a questionnaire, which has been previously devised and checked for its validity and reliability (Karkou 1996). Various statistical analyses, and especially factor analysis, had already indicated that the questionnaire had strong internal validity and might be utilised as a valuable tool for description of complex aspects of arts therapists' practice, including reliable assessment of their overall theoretical approach.

Conducting the pilot of the online survey ensured that this new mode of delivery had been very well received by the therapists, the new items were easily understood and their meaning was clear.

In addition, while the researcher had relatively little control over the numbers of potential respondents contacted and the sample may not therefore be representative

for music therapists (see section 4.2.2.1), high quality of the sample in terms of its suitability for the purpose of this project had been still assured. Contacts through the professional Associations and other respected and trusted networking groups ensured that only qualified and registered practitioners had been invited to take part.

Efforts were made to address credibility of this phase of the study by discussing methodological concerns in research seminars and sharing early findings in poster presentations in psychological and art therapies conferences in the UK and Europe.

3.5.1.2 Limitations

The most significant limitation of phase 1 of this research was the relatively low level of control that the researcher had over the recruitment process. While data protection issues made it difficult for the researcher to contact the potential respondents directly, it was trusted that the professional Associations would contact all of their members. However, usually the Associations' policies did not allow them to use members' e-mail addresses for advertising and therefore information about the survey was in most cases included in bulletins and newsletters, with no guarantee that it would reach the whole intended audience. Therefore, the fact that music therapists were underrepresented in the sample (see section 4.2.2.1) could originate from a relatively uncontrollable recruitment procedure rather than from those therapists' lower willingness to take part. It could be that the professional online networking and marketing channels were simply more effective in the environments of art, drama and dance movement therapists. Similarly, while the reached audience is not known, the response rate cannot be assessed, making it difficult to comment on the effectiveness of the online survey in comparison to the paper-based distribution (as in Karkou 1996).

The described limitations would be difficult to avoid, should the survey be replicated in the future. However, it would be valuable to receive additional information from the Associations, which could help establish the numbers of therapists they could reach and the ratio of these numbers to the total population of arts therapists in the UK (e.g. number of therapists on records, who subscribe to newsletters or who receive e-bulletins). In addition, should the research budget be more substantial, adverts could have been placed in professional journals as well, potentially reaching a wider audience.

The publisher of the paper presenting some of the results (Zubala et al. 2013, see page 344) suggested that additional information on arts therapists' ethnicity or a country within the UK where they practice would be valuable and it would be recommended that such data was collected in future studies.

Moreover, interviews with arts therapists working primarily with depression would have potentially provided data to allow for even more in-depth findings than those based on written answers to open-ended questions. A sample larger than seven therapists, as in this project, and including participants from all arts therapies would also be beneficial for more transferable conclusions.

3.5.2 Phase 2

3.5.2.1 Trustworthiness

Validity and reliability of the questionnaires used in this phase of the research was carefully checked, as was their applicability to the population in question.

While this was a small pilot study, its potential for assessment of feasibility of a larger study was considered very seriously and the project followed the procedure of a pretest, posttest and follow up study as rigorously as was possible, giving limitations of resources (see section 4.4.4 for further details).

Furthermore, it is acknowledged that researcher's bias could not be removed fully from participant observation process and in order to minimise it, the researcher engaged in de-briefing sessions with the therapist after each group session, this way allowing for a valuable perspective of another professional to be included in the findings. Interviews were conducted in a semi-structured format to allow for a person-centred approach as well as for scientific reliability and reduction of researcher's bias.

3.5.2.2 Limitations

Main limitations to the study included inability to conduct a randomised pilot trial and to include a control group potentially enabling comparison and conclusions regarding efficacy. The scope of the project could have been broader with inclusion of other arts

therapies. The reasons for these major limitations have been briefly outlined above and will be discussed in more details in section 4.4, where feasibility of a larger clinical trial is assessed.

Other limitations to this study included: lack of formal recruitment of a therapist and lack of opportunities for potential participants to enrol in the project in a way other than e-mail. These and other problem areas will be further scrutinised in section 4.4 where comprehensive evaluation of the project is offered.

3.6 Role of reflexivity

This project recognises the need for a researcher to constantly reflect on her practice, especially when it encapsulates intertwined perspectives of a student, clinician and a researcher. Thus, reflexivity understood as a “continual evaluation of subjective responses, intersubjective dynamics, and the research process itself” (Finlay 2002: 532), accompanied this project at all its stages.

It is recognised that the person of the researcher is at all times present throughout the research process, including preparation of background literature review, through to the study design, its conduct and report of the findings and results. While it is commonly acknowledged that qualitative paradigm requires the researcher to actively reflect on her/his responses to changing circumstances during the research process, the author believes that similar attitude should be expected from the researcher incorporating mixed methodologies and attempting creative research designs. Walker et al. (2013) notice that the postmodern research reality seems to accept that even hard science with robust quantitative outcomes is not free from the researcher’s bias and is never entirely objective. Therefore, mixed methods research with its complexities and inevitable uncertainties requires even more attention to be placed on how the research is conducted, why it takes a certain form and what is the researcher’s influence on it.

Reflexivity, a concept highlighting the need for the researcher to be aware of own research choices and their impact on the overall shape of the study and potentially its

outcomes (Finlay & Gough 2003), has been exercises throughout the project and continues to be in place while writing this report.

It is important to mention that, in addition to being used in research context, reflexivity is a term relating to therapy where it means the therapists' "ability to notice their responses to the world around them, other people and events, and to use that knowledge to inform their actions, communications and understanding." (Etherington 2004: 19) The author's background training in psychotherapy clearly influenced her understanding of reflexivity and required adapting the skill to the research environment. While the therapist would often take time to think about own reactions to what is happening in the therapy space, the researcher should similarly pause during the unfolding circumstances of the research, to reflect on its development in the light of own personal experience, preferences and beliefs. Understanding how personal background and research choices impact the final shape of the project is crucial for its quality and the eventual scientific value. Transparency in reporting the details of this process is similarly essential. The notes below will offer insight into how reflexivity was exercised in this project and highlight some moments, when it proved invaluable in moving the study forward and realising its actual meaning.

Firstly, the author has been aware that she attempted researching arts therapies as a psychologist and initially felt that being a not too distant "outsider" in arts therapies realm would be advantageous by enabling taking a more objective position. While this is believed to have happened, simultaneously the author often felt that the perspective of a psychologist/psychotherapist, while enriching the research process, was at times misleading and required additional effort to ensure that arts therapies perspective is primarily acknowledged. This was apparent in the process of establishing the intervention to be used in phase 2 of this research, when the author's training in verbal psychotherapy eventually proved useful and ensured that the role of verbal communication was not diminished. However, it also meant that additional background research needed to be undertaken in order to properly understand and acknowledge the role of an artistic process in the intervention. While the author embraces interdisciplinary research, opening an honest dialogue and contributing to strengthening connections between the disciplines of arts therapies, psychology and psychiatry

remains particularly important to her and should possibly be recognised as an influential feature of this project.

Reflexivity played a special role in conducting the pilot clinical project, where the researcher was expected to perform multiple tasks of a recruiter, an interviewer, a clinical assessor and a co-therapist. Different roles required sensitive approach in designing the procedures and undertaking them in practice. The author was aware of potential biases which presented threat to the project at this point. Therefore, she ensured that she fully understood her roles and took care to communicate them clearly to the participants. A particular attention was given to the therapy sessions and establishing the researcher's role as an observer. This role required the author to reconsider her tendency to entirely control the research process, to understand that research is essentially co-constituted (Finlay 2002), to accept an input of other people in the process, and to eventually embrace its scientific and personal value. In undertaking clinical assessments prior to the intervention it became particularly important to ensure that the participants understood the limitations of the researcher's role in offering actual psychological support. Author's particularly intense dialoguing with self took place during and following the initial interviews when her personal responses to participants' stories were especially strong and required conscious reconsidering of own role and balancing the duties of care with the expectations of the project.

Data analysis and especially amalgamating findings and results in a more coherent structure required a particular type of reflection and negotiation between personal beliefs and perceived expectations of the research outcomes. Decision to continue with creative approach to research through to the report of its findings was eventually made with acknowledgement of opening a potential for critique and a risk of bias. However, dialoguing with self led to a clear conclusion that the true value of this project lied in its openness towards creative research approaches and the actual readiness to implement them meaningfully throughout the process. The author at the same time ensured that this ambition was led by an honest belief, supported by literature-based and anecdotal evidence, in the value of innovative designs.

The process of reflexivity is continuing (and will be continued beyond the process of writing of this thesis) in considering how the findings of this research are presented to various audiences and making sure that its essence is communicated to different

recipients in a comprehensible but always scientific manner, without losing essential quality. While the author recognises the potential of this project to offer value in areas of healthcare, education and academia, it remains crucial that the actual impact is considered with modesty and appropriately to the culture of the specific environment. Being mindful of own preferences and their impact on synthesizing the leading ideas from this project seems essential in preparation of publications and research presentations, as well as in considering further research plans. Thus, the process of reflexivity is expected to continue far beyond the project itself.

3.7 Making connections: methodological links between the two phases

While the two phases of this research were methodologically very different, their complexity and certain sequence directly reflected the needs of the research questions and created a consistent research design. Both major research questions demanded qualitative and quantitative perspectives within very different methodologies of a survey and a pilot clinical study. Two phases of the research concerned two different but interconnected populations of therapists and clients. This research was interested in neither of the groups essentially, but rather in the process of therapy itself and its deeper sense: practically – in its potential effectiveness, and clinically – in its meaning. Gaining perspectives from both the facilitators and the participants of therapy was essential for creating as holistic as possible picture within a modest scale study. Only after therapists' methods of working were known, could an art therapy intervention be devised for the purpose of this project and eventually evaluation of the process by participants became possible. In both phases quantitative data offered a more general guide and an idea of tendencies, while qualitative data enriched findings by giving them a more comprehensible and much deeper perspective with additional layers of meanings, unfolding through the process of analysis. In that sense, separate parts of this project may still offer some insights into arts therapies practice with depression, but only the interconnectedness of the methods, data sources and their place in the research timeline may offer a truly holistic picture.

4. Findings and initial discussion

4.1 Introduction

The findings of this methodologically complex research will be presented in two separate sections for each phase of the study, before main conclusions are drawn in chapter 5 (Core discussion). Since the phases were conducted sequentially, the results will also be presented in a chronological order, as they were obtained. Firstly, the more descriptive in nature results from phase 1 will be discussed, to be followed by more exploratory findings from phase 2. Third section of the chapter will be entirely dedicated to assessment of feasibility of a potential study on a larger scale.

Whenever multiple methods are used for data collection and analysis, integration of datasets becomes crucial for the meaning of the project. Special attention is therefore given to subsequently connecting information derived from various methods and sources while presenting results and findings. Initially, in order to increase transparency, individual findings are presented, as and when they occurred in the process of analysis. It may occur to the reader that the amount of substance in findings often increases with time, as new meanings are discovered in this exploratory process. For clarity, short summaries often follow presentation of more detailed results and attempts are made to eventually draw meaningful connections between qualitative and quantitative paradigms in explaining the researched subject. Such comprehensive links are offered on two occasions, following detailed presentation of: results in phase 1 (section 4.2.4) and finding in phase 2 (section 4.3.3).

Quite uncommonly, elements of discussion are integrated in this chapter and often accompany more specific findings. Decision to introduce discussion at this early stage of reporting findings was inspired by the unusually complex nature of methodology and intention for the findings to meaningfully unfold throughout the presentation. Thus, some of the points further raised in chapter 5 (Core discussion) are included immediately after relevant findings, as and when they emerged in the analysis, which has an additional benefit of increased transparency of the process.

4.2 Phase 1: Description of arts therapies practice with depression

Description of arts therapies practice with depression will be offered through presentation of findings originating from two surveys among arts therapists working in the UK. In the first section, quantitative results from the main Arts Therapies Survey will be presented, based on analysis of quantifiable items. Following section will be dedicated to the two sets of qualitative findings, based on analysis of: 1) open-ended items in the main Arts Therapies Survey and 2) separately presented findings from depression-specific questionnaire. The two sets of qualitative findings will then be integrated. Finally, connections between the two modalities of findings will be offered.

4.2.1 Introduction

The Arts Therapies Survey 2011 that collected both quantitative and qualitative data closed in November 2011. The survey was completed by 395 arts therapists of all four disciplines recognised in the UK, that is: art psycho/therapy (AT), music therapy (MT), dance movement psychotherapy (DMP) and dramatherapy (DT). Seven of the arts therapists who worked specifically with depression took part in a detailed follow-up qualitative questionnaire, sent to them in December 2011. Both quantitative and qualitative analyses were performed on the collected data and supported by SPSS19 and NVivo9 software. The results are presented below, in two separate sections for increased clarity. (Please note that many direct quotes from arts therapists are labelled with respondent's number and main therapy type they declared to be using.)

4.2.2 Quantitative findings

4.2.2.1 General characteristics of the sample and its representativeness

In this study an unknown initial sample size prevents from calculating the exact response rate (see section 3.5.1.2). However, the final sample included 395 participants, which constitutes 12.12 % of the total population of arts therapists in the UK, estimated at 3259 at the beginning of year 2012.

Arts therapists of all disciplines recognised in the UK took part in the survey. Art therapists / psychotherapists formed the largest group (AT, n=243, 61.52% of the total sample of 395) followed by dramatherapists (DT, n=59, 14.94%), music therapists (MT, n=50, 12.66%) and dance movement psychotherapists as the smallest group (DMP, n=36, 9.11%). These figures roughly correspond with the proportions of arts therapies disciplines among the total population of arts therapists in the UK.

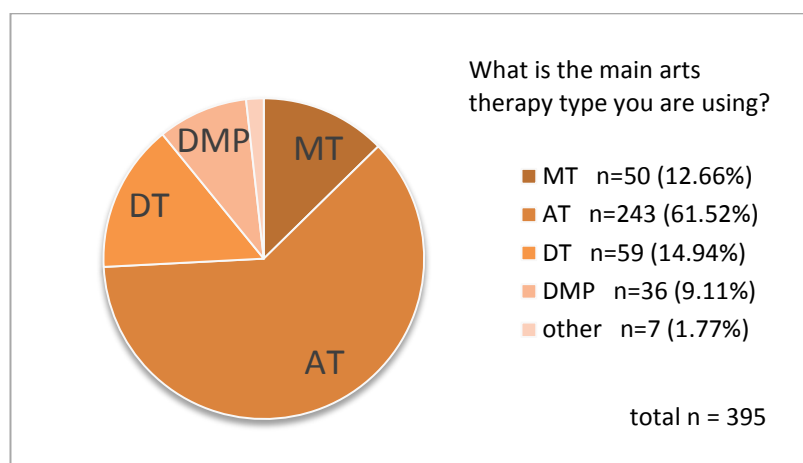


Figure 6: Arts therapies disciplines represented in the Survey.

According to the information available on Health Professions Council's website (HPC 2011) and gained from ADMP UK, in the total number of arts therapists in the UK art psychotherapists form the largest group (AT=52.26%), followed by music therapists (MT=22.83%), dramatherapists (DT=18.41%) and dance movement psychotherapists (DMP=6.51%).

	AT		MT		DT		DMP	
	n	%	n	%	n	%	n	%
General population	1703	52.26	744	22.83	600	18.41	212	6.51
Sample	243	61.52	50	12.66	59	14.94	36	9.11

Figure 7: Number of arts therapists in the general population and in the sample.

Analysis of proportions has shown that the difference in the presence of ATs and MTs in the sample and in total population of arts therapists is statistically significant at 95% confidence interval (ATs: $z=2.7610$, MTs: $z=2.0366$), however no statistical difference is

observed in the presence of DTs and DMPs. The conclusion seems to be that while the sample represents the proportions of DTs and DMPs in the population of arts therapists well enough, it includes too many ATs and not enough MTs. To be truly representative and resemble the exact proportion of disciplines' practitioners in the whole population of arts therapies, the sample would ideally include more MTs and fewer ATs. This limitation would need to be considered when interpretation of results is made and conclusions are drawn, which may more accurately apply to ATs, DTs and DMPs than to MTs. Representativeness and potential for generalisability of this sample is further discussed in section 3.5.1.

The sample consisted in 84% of female respondents and in 16% of male respondents. This ratio corresponds to the approximate number of females and males in the total population of arts therapists in the UK (no statistical differences between the respective groups were found). According to HPC (2011) statistics, total percentage of female arts therapists (ATs+MTs+DTs) is 82.57%, while male arts therapists: 17.33% (DMPs were not accounted for, not being members of HPC, but even stronger dominance of females is expected in this group of arts therapists). With enough confidence, this sample can therefore be treated as representative for the whole population of arts therapists in the UK in relation to gender.

4.2.2.2 Groups of arts therapists relevant to the study

For the purpose of this study, the questionnaire (see Appendix 1) included two specific items (27a, 27b) to allow for identification of arts therapists, who worked mainly with depression – the focus of this phase of the research. An astonishing 91.4% of arts therapists (n=361) stated that there were people suffering from depression among their clients (item 27a). Of this group, 18.6% (n=67) considered people suffering from depression to be their main client group (item 27b).

Answers to questions 27a and 27b therefore allowed for identification of three exclusive groups of arts therapists: those, who worked primarily with depression (group D+), those, who did not work with depression (group D-) and those, who have people with depression among their clients, but did not consider them to be their main client group (D+/-). In the analysed sample, group D+/- was the largest, with 74.4% of therapists

meeting the criteria. 17% of arts therapists declared that they worked mainly with depression (D+, n=67), while only 8.6% stated that they did not encounter depression in their practice (D-, n=34).

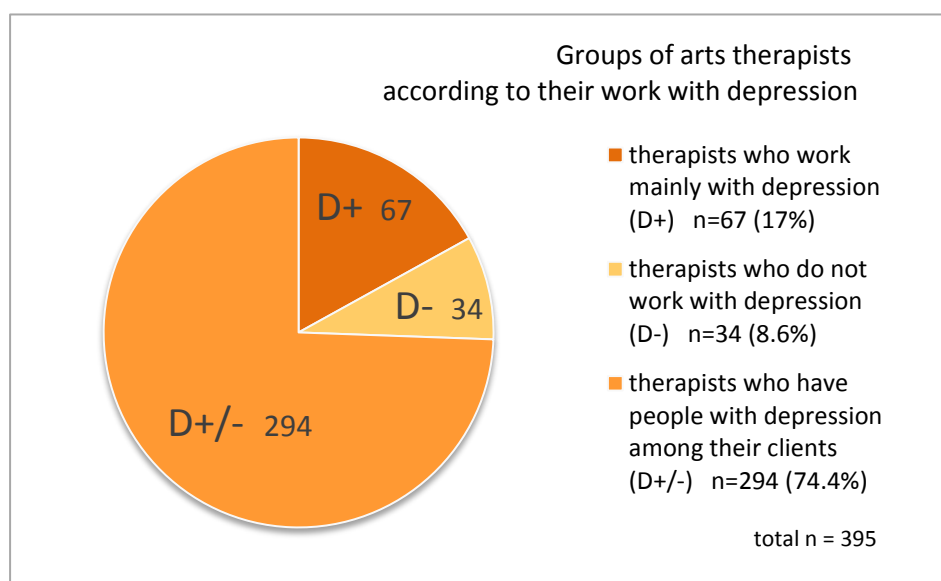


Figure 8: Groups of arts therapists, according to frequency and/or intensity of work with depression.

4.2.2.3 Comparison of three groups of arts therapists

In order to increase understanding of how arts therapists worked with depression, a number of comparisons were performed as indicated in the following sections.

4.2.2.3.1 Biographical information of arts therapists (sex, age, experience)

The proportion of female to male therapists (question 21) was roughly the same in all three groups of respondents (D+: 88%:12%; D-: 85%:15%; D+/-: 83%:17%), while the age of respondents (question 22) differed between groups (see Figure 9). Nearly 30% of arts therapists, who did not work with depression (D-) were under 30 years old, while only 4.5% of those, who specialised in working with depression (D+) belonged to this age group (in group D+/- this figure was 6.8%). The difference between groups D+ and D- is statistically significant at 99% confidence interval ($z=2.9888$).

Also, more respondents in group D- reported to have fewer years of experience (question 23) than in group D+; 50% of therapists, who did not work with depression, had

less than three years experience in comparison to 19% in group D+ (and exactly the same, 19%, in group D+/-). The difference between groups D+ and D- is statistically significant at 99% confidence interval ($z=3.0685$). These figures are not surprising, while experience seems to be closely dependant on age.

Biographical information of arts therapists		D+	D-	D+/-
sex	F	88.1%	85.3%	83.0%
	M	11.9%	14.7%	17.0%
age	< 30	4.5%**	29.4%**	6.8%** ^{D-}
	31-40	19.4%	23.5%	23.5%
	41-50	34.3%	14.7%	28.9%
	51-60	28.4%	20.6%	31.3%
	>60	13.4%	11.8%	9.5%
years of experience	< 3	19.4%**	50.0%**	19.0%** ^{D-}
	4-7	20.9%	8.8%	15.0%
	8-11	22.4%	11.8%	16.7%
	12-15	4.5%	8.8%	14.3%
	> 15	32.8%	20.6%	35%

Figure 9: Biographical information of arts therapists in three groups (highlighted areas of statistically significant difference: ** at 99% confidence interval).

A conclusion may be risked that working with depression generally requires more experience from the therapists. Such result may as well be dictated by the notion that experience (and therefore time) is generally needed for a clinical professional to specialise in certain condition or approach. However, the last interpretation would need to be rejected, as therapists from group D+/- are more similar to group D+ in terms of age and experience. It seems therefore significant that among therapists, who do not encounter depression in their practice, 50% are relatively inexperienced. May this figure result from the difficulties with the diagnosis of depression and less experienced therapists may simply not diagnose their clients properly? Or may it be that younger and less experience therapists are more likely to ignore co-morbidities and attribute certain dominant condition, other than depression, to their clients (e.g eating disorder, while depression is 'hidden' behind it)? Would older and experienced therapists be, on the other hand, more prone to look at their clients holistically and therefore notice depression more often, even behind other dominant problems? This interesting and complex subject is not in the scope of this project, but could well be explored in a separate research.

4.2.2.3.2 Arts therapists' style of working (work environment, group vs individual work, work alone vs in a team)

Therapists in all groups answered that they worked on their own as well as in a team with other professionals (question 8) equally often and both styles of working were reported by between 47.1 and 65.7% of therapists, regardless of whether they work with depression or not. In addition, between 26.5 and 33.2% of therapists in all groups worked in a team with other arts therapists. Differences within groups were not significant. Similarly, working alone or in a team with other professionals seemed to be equally most common style within arts therapies practice, while working with other arts therapists was reported to be fairly often present but a less common practice.

In contrast, therapists' answers to the question about main working environment (question 7) differed largely, depending on whether they worked with depression or not. Arts therapists, who specialise in working with depression (group D+), reported that health service was their main working environment most often (55.2%), while only 11.8% of therapists, who did not work with depression, chose this option (difference significant at 99% confidence interval, $z=5.2245$). On the contrary, 32.4% of therapists from group D- and only 7.5% from group D+ worked within educational setting (difference significant at 99% confidence interval, $z=2.8398$). No significant differences between groups D+ and D- were found in relation to working in voluntary sector, social services or private practice. Responses of therapists from group D+/- may be placed somewhere in between (54.2% work in health service, 13.9% in educational setting) but closer to group D+ (no significant differences between D+/- and D+) than D- (differences between D+/- and D- statistically significant, see Figure 10 for details).

To sum up, therapists in groups D+ and D+/- are most (and equally) likely to work in a health service, while therapists in group D- work mostly in educational setting or private practice. Therefore, arts therapists' practice with depression seems to be often required within health services while it is very rarely present in educational settings.

This finding seems to be somehow related to the age of clients, with whom therapists work. Most therapists in group D-, not surprisingly, while working in educational setting, state that their clients are children (61.8%) and adolescents (55.9%). They work with young adults (32.4%) and adults (47.1%) less often and very rarely work with older people

(5.9%). Exactly the opposite is true for group D+, where therapists much more often work with adults (80.6%) and young adults (52.2%) than with children (17.9%) or adolescents (28.4%). Also, they work with older people relatively often (28.4%). Differences between groups D+ and D- are statistically significant at 99% confidence interval in most cases (see Figure 10 for details). Group D+/- is again somewhere in the middle, with less defined differences between the frequency of working with different age groups. However, adults and young adults remain the main client group (significant difference in relation to group D-), while work with children and adolescents happens often (significant difference in relation to group D+) and work with older people is the least common (again, differently to group D-).

Both criteria, the main working environment and the age range of clients, suggest that tackling depression is a very common theme in arts therapists' work with adult clients, while it appears much less often in the work with children or adolescents. This may be an implication of a fact that prevalence of depression is highest among adults aged 25 to 64 (Rait et al. 2009; CDC 2012). Alternatively, it may indicate that in the work with children and adolescents other themes are likely to dominate, with depression presumably 'hidden' or covered behind them in some cases.

Therapists in all three groups agreed that they worked with individual clients most often (between 82.4 and 85.3%), while work with families or couples was the least common (between 20.9 and 23.5%). However, work with groups was reported by 71.6% of therapists in group D+ and only 50.0% therapists in group D- (difference significant at 95% confidence interval, $z=2.0924$), with group D+/- being again in between, but much closer to group D+ (68.5%, significant difference in relation to group D-, $z=2.0298$).

The simple conclusion here seems to be that, while individual therapy is offered most often, the therapists, who do not work with depression, are more likely to work on one-to-one basis, while group work is much more common when depression is being addressed. Such result indicates that arts therapists, who specialise in working with depression, value the benefits of group work for their clients.

<i>Arts therapists' style of working</i>		D+	D-	D+/-
lone and/or team work	on my own	65.7%	61.8%	54.2%
	team -with other arts therapists	26.9%	26.5%	33.2%
	team -with other professionals	58.2%	47.1%	59.7%
	Other	2.9%	5.9%	7.5%
main working environment	health service	55.2%**	11.8%**	54.1%** ^{D-}
	educational setting	7.5%**	32.4%**	13.9%** ^{D-}
	private practice	17.9%	23.5%	11.2%
	voluntary agency	10.4%	14.7%	7.5%
	social service	3.0%	5.9%	7.1%
	other	6.0%	11.8 %	6.1%
age range of clients	children <11	17.9%**	61.8%**	44.4%** ^{D+}
	adolescents 11-16	28.4%**	55.9%**	40.0%
	young adults 17-25	52.2%	32.4%*	52.2%** ^{D-}
	adults 26-65	80.6%**	47.1%**	70.8%** ^{D-}
	older people >65	28.4%**	5.9%**	25.8%** ^{D-}
one-to-one and/or group work	one-to-one	85.1%	85.3%	82.4%
	families/couples/diads	20.9%	23.5%	23.1%
	groups	71.6%*	50.0%*	68.5%** ^{D-}

Figure 10: Arts therapists' style of working in three groups of respondents (*highlighted areas of statistically significant difference: * at 95% confidence interval, ** at 99% confidence interval*).

4.2.2.3.3 Arts therapies disciplines in three groups of arts therapists

Arts therapists of various disciplines were represented in the three groups in different proportions, with group D+/- being most similar to the total sample (see Figures 11 & 12). Groups D+ and D-, however, differ significantly, with art therapists (ATs) being overrepresented in group D+ (73.1%) and underrepresented in group D- (47.1%) in relation to the total sample (61.5%). The presence of ATs in the groups D+ and D- is statistically significantly different at 95% confidence interval ($z=2.5338$), as it is in groups D+ and D+/- ($z=2.0935$). Dramatherapists (DTs), on the other hand, are better represented in group D+ (19.4%) than in any other group, including the total sample (result not statistically significant), while music therapists (MTs) are significantly underrepresented in group D+ (1.5%) in comparison to their presence in other groups, including total sample, which vary between 12.7% and 15.0% (significant difference at 95% confidence interval and $z=2.0810$ between groups D+ and D-, at 99% confidence interval and $z=5.2588$ between D+ and D+/-). While proportion of dance movement therapists (DMPs) in group D+/- (8.8%) is nearly the same as in the total sample (9.1%), it is lower in group D+ (4.5%) and much higher in group D- (20.6%). The difference between DMPs presence in groups D+ and D- is statistically significant at 95% confidence interval ($z=2.1500$).

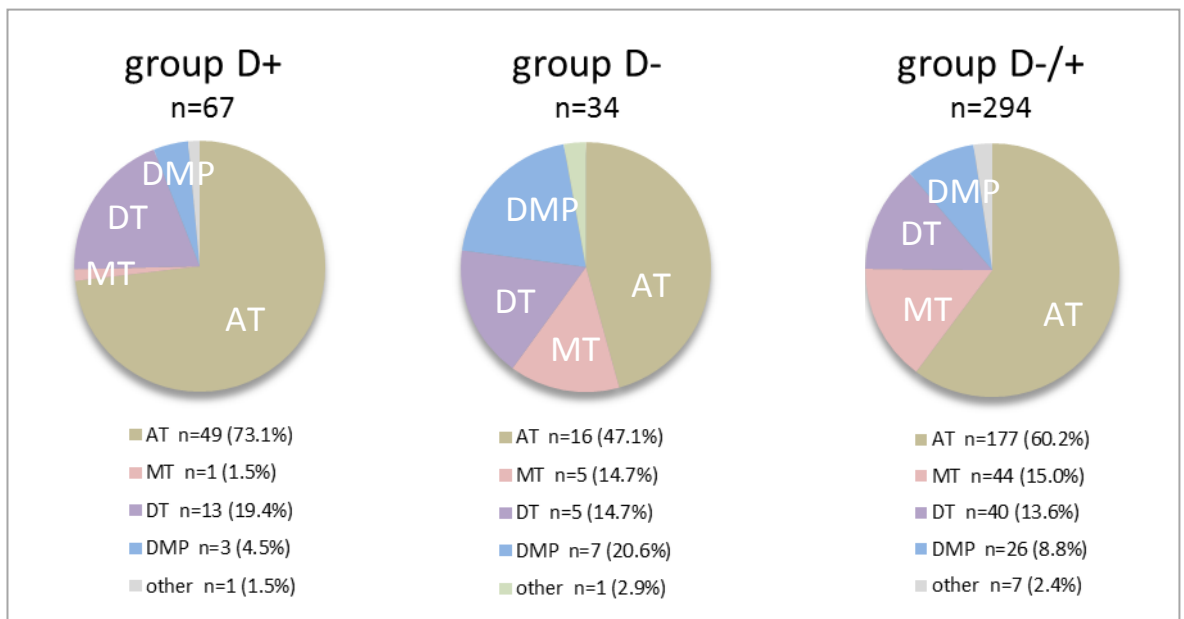


Figure 11: Percentage of arts therapies disciplines in groups D+, D- and D+/-.

For clarity and increased understanding, the same data has also been looked at from a different perspective. Figure 12 illustrates the percentage of therapists from different groups (D+, D- and D+/-) within each of arts therapies disciplines. Both figures (11 & 12) seem to suggest that working with depression specifically is relatively more common among art therapists and dramatherapists (20% and 22% of total sample, respectively) than it is among music and dance movement therapists (2% and 8% of total sample, respectively). The difference is statistically significant (at either 95% or 99% confidence interval) between ATs and MTs ($z=5.5256$), ATs and DMPs ($z=2.2825$), DTs and MTs ($z=3.4510$) and DTs and DMPs ($z=1.9678$), while it is not significant between ATs and DTs, and between MTs and DMPs.

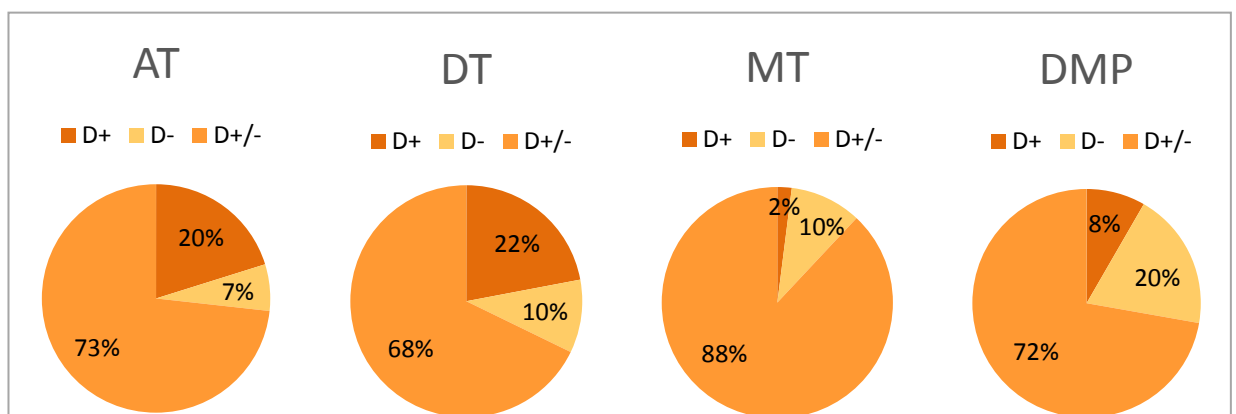


Figure 12: Percentage of arts therapists from different groups (D+, D- and D+/-) within each of arts therapies disciplines.

Moreover, other differences between groups of therapists seem apparent. While particularly low percentage of music therapists works with depression specifically (2%), they still work with clients, who have symptoms of depression (88%) very often. In comparison, dance movement therapists seem to be the group working with non-depressed clients most often (20% of DMPs) in relation to other disciplines (between 7% and 10% among ATs, MTs and DTs). The difference in the frequency of working with non-depressed clients between ATs and DMPs is statistically significant at 90% confidence interval ($z=1.8685$).

A note should be taken that, since the sample may not be representative for the total population of music therapists (see section 4.2.2.1), the above results need to be considered with this limitation in mind.

4.2.2.3.4 Severity of depression as reported by arts therapists

Therapists, who stated that there were people with depression among their clients (groups D+ and D+/-), were also asked to estimate the severity of majority of their clients' condition (question 27a). Arts therapists, who consider themselves to have specialised in working with depression (group D+), tended to respond that their clients' condition was severe more often than those, who work with depression alongside other conditions (group D+/-). In group D+ ($n=67$), 60% of respondents described the depression of majority of their clients as severe, 37% as moderate and only 3% as mild. For comparison, exactly 50% of the therapists in group D+/- ($n=294$) described their clients' condition as moderate, 40% as severe and 10% as mild. The difference between two groups is statistically significant at 95% confidence interval in all levels of the severity of depression: severe ($z=2.9963$), moderate ($z=1.9632$) and mild ($z=2.5593$).

Generally, therapists from both groups tended to consider their clients' depression to be severe relatively often and rarely evaluated it as mild. It is important to acknowledge that analysed were the subjective judgements made by arts therapists, not necessarily confirmed by clinical diagnoses. The perception of severity of depression may differ quite significantly among various groups of professionals, according to separate criteria, based on, for example, behaviour, social functioning, psychological condition or combination of these factors in various proportions (Shankman & Klein 2002). There may

be several reasons for the more severe depression estimated more often by group D+ than D+/-, which this project cannot explore further. It seems natural that therapists, who consider themselves specialists in working with depression, would choose to work with more severe cases, for which their experience is suitable. However, it may also be true that those, who work mainly with depression, are highly sensitive towards its symptoms and tend to notice them more often, when other therapists may remain unaware of them. These and other reasons could be explored further in future research.

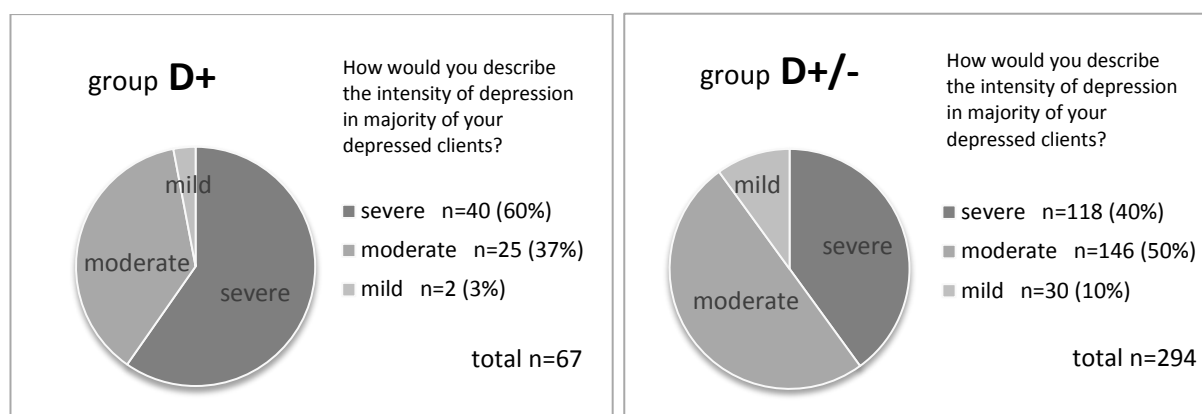


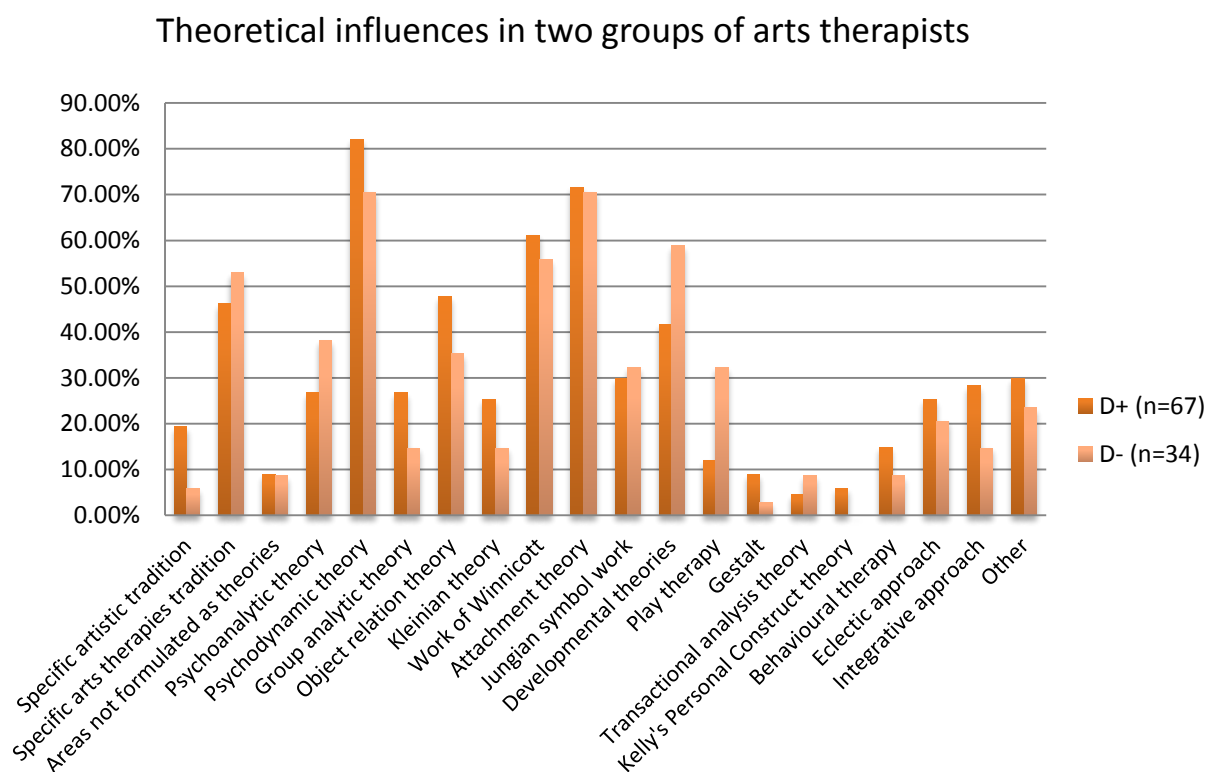
Figure 13: Intensity of client depression, as described by therapists from groups D+ and D+/-.

4.2.2.4 Theoretical influences in two groups of arts therapists

The two groups of arts therapists (D+ and D-) were also compared on self-reported theoretical influences (question 9). Visual analysis of gathered data revealed similarities in both groups, with strongest influences (reported by at least 40% of respondents) in 'Psychodynamic theory', 'Attachment theory', 'Work of Winnicott', 'Specific arts therapies tradition', 'Object relation theory' and 'Developmental theories'. The least popular influences (chosen by less than 10% respondents) include: 'Gestalt', 'Transactional analysis theory' and 'Kelly's personal construct'.

Chi-Square tests were performed to determine whether groups D+ and D- differ in their self-reported theoretical influences. Statistical difference between groups was observed in relation to Play therapy. Play therapy as one of the theoretical influences was reported by over 32% of arts therapists who do not work with depression (D-) and by less than 12% of arts therapists who work mainly with depression (D+). The Pearson Chi-

Square test confirmed that arts therapists in group D- regard Play therapy as one of their theoretical influences statistically more often than therapists in group D+ ($p=0.013$).



In addition, analysis of proportions revealed statistically significant differences between groups at 95% confidence interval in Play therapy ($z=2.2505$) and two other influences: Specific artistic tradition ($z=2.1255$) and Kelly's Personal Construct theory ($z=2.0470$). A weaker significant difference (at 80% confidence interval) was also found in relation to Developmental theories ($z=1.6219$).

The results seem to suggest that arts therapists, who work with depression specifically, are more likely to be influenced by 'Specific artistic tradition' and 'Kelly's Personal Construct theory' than those, who do not work with depression. On the other hand, arts therapists in group D- report more often than those in group D+ that they are influenced by 'Play therapy' and 'Developmental theories'.

Overall though, while certain theoretical influences are more popular among arts therapists in general, they seem not to significantly differentiate between those therapists who work mostly with depression and those, who do not.

4.2.2.5 Preferences for particular therapeutic approaches in two groups of arts therapists

Two groups of arts therapists (those, who work mainly with depression (D+,n=66) ¹ and those, who do not work with depression (D-, n=34)) were compared to determine whether there is a difference between them (and if so, in what direction?) in relation to preference for specific therapeutic approaches (six factors identified by Karkou in 1998). Results revealed that preferences for therapeutic approaches of arts therapists who work mainly with depression (D+) differ from preferences of therapists who do not work with depression (D-).

Arts therapists in group D+ (n=66) agree most strongly with Humanistic principles, then with Psychoanalytic, Eclectic/Integrative, Developmental, Artistic/Creative and least with Active/Directive principles (in order of the level of agreement).²

	Theoretical approach	mean	std. deviation
1	Humanistic	2.0238	.54244
2	Psychoanalytic/Psychodynamic	2.0811	.60390
3	Eclectic/Integrative	2.1545	.60744
4	Developmental	2.3409	.75304
5	Artistic/Creative	2.4465	.50866
6	Active/Directive	2.8355	.86960

Figure 15: Preferable therapeutic approaches among arts therapists in group D+ (n=66) – in order of preference.

¹ Responses of one of the participants in group D+ were excluded from the analysis, as over 50% of data was missing and therefore n=66 rather than 67 as in initial dataset.

² Note that lower means indicate higher level of agreement, on a 5 point scale, where 1=strongly agree and 5=strongly disagree.

An independent samples t-test was conducted to examine whether there was a significant difference between the two groups of arts therapists in relation to their preferred theoretical approaches. The test revealed a statistically significant difference between group D+ and group D- in relation to the Psychoanalytic/Psychodynamic factor ($t = -2.051$, $df = 98$, $p = 0.043$). Arts therapists, who work mainly with depression (D+, $M=2.0811$, $SD = .601$) agree more strongly with Psychoanalytic/Psychodynamic principles than arts therapists, who do not work with depression (D-, $M=2.3529$, $SD = .673$).

Therapeutic factors	client group	N	Mean	Std. Deviation	Std. Error Mean
Humanistic	group D+	66	2.0238	.54244	.06677
	group D-	34	2.0672	.47215	.08097
Psychoanalytic/Psychodynamic	group D+	66	2.0811	.60390	.07434
	group D-	34	2.3529	.67321	.11545
Developmental	group D+	66	2.3409	.75304	.09269
	group D-	34	2.2088	.62686	.10751
Artistic/Creative	group D+	66	2.4465	.50866	.06261
	group D-	34	2.6618	.60648	.10401
Active/Directive	group D+	66	2.8355	.86960	.10704
	group D-	34	2.8035	.74813	.12830
Eclectic/Integrative	group D+	66	2.1545	.60744	.07477
	group D-	34	2.0974	.68777	.11795

Figure 16: Comparison of two groups of arts therapists (D+ and D-) in relation to the six factors, with significant difference highlighted.

4.2.2.6 Summary of quantitative findings

The group of arts therapists who took part in the study ($n=395$) is a representative sample of the population of the art, drama and dance movement therapists in the UK, while it is not necessarily representative of the music therapists. The responses confirm that arts therapists of all disciplines often work with depression, with only small group of therapists admitting that they do not encounter this condition in their practice. Arts therapists who work with depression (group D+) were compared to those, who do not work with depression (group D-) and to those, who have people with depression among their clients, but do not consider depression the core problem of their main client group (group D+/-).

The quantitative analysis revealed that the therapists in the three groups differ significantly on a number of variables, including years of experience, age, main working environment, clients' age group and style of working. Therapists, who specialise in working with depression, generally tend to be more experienced than those, who do not work with depression; they also work in health environments more often and are more likely to work with groups. The proportions of arts therapists of different disciplines within groups indicate that drama and art therapists were more likely to work with depression than music and dance movement therapists. Furthermore, arts therapists, who work with depression, often tend to describe their clients' condition as severe and moderate, with most therapists in group D+ indicating that they work with severe depression. While common theoretical influences were generally indicated by the therapists in groups D+ and D-, analysis of factors identified by Karkou (1998) revealed stronger agreement of group D+ with Psychoanalytic principles.

The results help to describe arts therapists' work with depression and explain how it may be different to the work with other conditions. In addition, they supported the development of the treatment manual for phase 2 of this research (see section 4.2.4.2).

4.2.3 Qualitative findings

4.2.3.1 Introduction to categories and themes

It has been earlier explained (see section 3.3.5.2) how the principles of template analysis were employed in the process of data preparation, coding and analysis of arts therapists' responses to open-ended questions in the main Arts Therapies Survey. Analysis was performed on 182 responses collected from therapists, who work with depression. In the result, themes were identified and grouped into three categories to provide meaningful structure to the analyzed data. Sections 4.2.3.2 to 4.2.3.4 describe and explore these concepts in more detail.

Additional analysis was performed on the data collected through a follow-up depression-specific questionnaire, in which seven arts therapists, who work primarily with depression, took part. This material, which provided further insight into arts therapists

work with depression and helped shape the treatment manual for phase 2 of this research, is commented on in section 4.2.3.5. Eventually, an attempt to combine the findings from both questionnaires is offered in section 4.2.3.6.

Figure 17 presents nine themes within the three categories which emerged from 182 responses to open-ended items of the main Arts Therapies Survey. It is important to acknowledge that all categories and themes were based solely on arts therapists' comments and therefore can only represent the respondents' specific experience with working with depression and do not claim to provide objective frame for any other therapeutic work undertaken on this condition.

Categories	1. Information about arts therapists	2. Characteristics of clients with depression	3. Working with depression
Themes	1.1 Setting, character of work and length of therapy 1.2 Therapeutic approaches 1.3 Assessment and evaluation	2.1 Client groups 2.2 Main underlying problems 2.3 Nature of depression	3.1 Tools/interventions used in therapy 3.2 The role of therapeutic process 3.3 Benefits of arts therapies

Figure 17: Categories and themes identified in thematic analysis of responses to open-ended questions in the main Arts Therapies Survey.

The categories and themes identified through analysis will now be presented in more details. Specific sections are preceded with selected quotes from the respondents aiming to introduce and illustrate the discussed concepts. It was especially important for the researcher to enrich the presentation of findings with arts therapists' voices, often more accurate and vivid than her own interpretative remarks.

4.2.3.2 Category 1: Information about arts therapists

In response to open-ended questions, arts therapists shared significant amount of information about themselves as professionals, including details about their workplaces, the character of their work and usual length of therapy. Responses to items 10 and 19

gave more insight into the theoretical framework on which therapists base their practice and into the commonly used procedures for assessment and evaluation of therapeutic work.

4.2.3.2.1 Setting, character of work and length of therapy

*“The challenge is to keep the integrity of the [art] psychotherapy process and to adapt it to the changes and demands in a culture which is governed by targets.”
(therapist 207, AT)*

Work environments most often mentioned by the respondents included acute wards within NHS mental health hospitals, community adult mental health teams, mental health centres run by voluntary organisations, schools, private practice, forensic mental health unit and a prison. It was noted that the work setting may significantly affect both the quality of work and techniques applied, as one therapist described: “the setting (institution) has been very present (...) and I have had to work with this in mind at all times, and this has inevitably affected my practice and what has been possible” (t.121,AT). Another respondent, who worked in the NHS for many years, commented that “so much [was] pinned down and narrowed down via NICE etc.” (t.67,AT). Generally, arts therapies practice seems to be challenged by both demands from guidelines and rules of the setting and personal and professional convictions and therapists are aware of the need to achieve the balance.

Arts therapists most often stated that they worked with groups (“closed groups and studio type groups”), but also mentioned working with individual clients/patients. Advantages of both modes of working were noted. Individual work with patients in acute ward has been described as valuable for building relationship and trust before further therapeutic work can be attempted. Group work was also described as beneficial (“supportive and positive”) to clients/patients with depression. In the words of one respondent: “Group work is good for those with moderate depression as it normalizes emotional pain; anxiety can be greatly reduced through group work” (t.357,AT).

Three respondents provided information about the duration of typical treatment. According to these accounts, the length of therapy varies significantly (“from a few sessions to four years”). One of the participants, music therapist working in NHS service

for people recovering from an acute phase of mental illness, stated that the treatment (open group therapy) normally lasts 12 weeks. The same respondent occasionally offers short-term therapy to individual patients, which

“does not offer people treatment to work through, resolve their problems, but can support people to think about how to get back on their feet and consider different ways they could approach their longer-term recovery.” (t.256,MT)

Another respondent, art therapist with extensive experience of working with clients affected by depression in adult mental health, stresses the importance of long-term therapy for this client group (“[clients] required longer term approach – often very successful outcomes” t.361,AT). Similar idea will be further explored in the findings again, in the form of a separate sub-theme of Time (see section 4.2.3.4.2).

4.2.3.2.2 Therapeutic influences

*“My practice, although evolves, has always had a strong leaning towards the body-mind as a whole system. See therapy as educative, reparative and healing.”
(therapist 379, DT)*

Theoretical influences have been commented on as a response to item 10. Diverse theoretical backgrounds from psychological theories to arts specific approaches were mentioned by the respondents and many names of theories’ founders/creators have been given.

The work of Donald Winnicott was the most often mentioned influence (noted by 4 respondents). Influences which appeared at least three times include: the work of Carl Gustav Jung, attachment theory, developmental EPR theory (Sue Jennings), psychodynamic theory, group analysis and eclectic/integrative approach, which is often adopted when work is carried out with “many different types of clients in a variety of settings” (t.169,AT). One of the respondents, art therapist, explained the reason for integrating various approaches in his/her practice:

“The current challenge to ‘treat’ i.e. evidence improvement in long term clients within an NHS complex case service using time limited interventions has encouraged me to adapt and adopt whatever feels appropriate.” (t.141,AT)

Another art therapist added: “I had to adapt my practice and develop a particular way of working, due to the severe restrictions inherent in the environment I was in.” (t.121,AT) Since various care settings value certain philosophical or therapeutic approaches, this clearly influences the work of arts therapists, as in this example:

“I work in a multicultural team, so this informs the philosophy of the team – generally psychoanalysis is seen as too Eurocentric to be relevant to most groups of people attending our community mental health team.” (t.126,AT)

Therapeutic communities’ influence on the practice was noted twice, as was the experience and own practice as an artist. Other theoretical influences mentioned by participants, with names of the main theorists/representatives (wherever applicable and if given by respondents) include (in no particular order): anti-psychiatry (R. D. Laing), art as healing (S. McNiff, L. McLagan), brief approaches to art therapy, CBT mindfulness, creative AT models (M. Thomson), developmental theories (R. Steiner, M. Montessori), humanistic approach, object relations theory (M. Klein), systemic therapy, interpersonal therapy, positive psychology, narrative approaches, holistic practice, Neuro-Dramatic-Play, Nordoff-Robbins music therapy, improvisational music therapy, social construction theory, feminism and politics of diversity, theory of flow, intersubjectivity and elements/nature. Other names, specified by the respondents, include: D. H. Baucom, A. T. Beck, S. Freud, S. Johnson, E. Landy, D. N. Stern, S. Scaife, G. B. Shaw, T. Mann. Supervision was also named by one of the participants as a major influence.

4.2.3.2.3 Assessment and evaluation

*“(...) the only other evidence based results I can offer is the seeing of the clients going off into the world much happier.”
(therapist 298, other)*

Open-ended question 19 allowed the participants to share their views about assessment and evaluation of their work with clients. Responses provided insight into various aspects of assessment in therapy, within the three main areas which can be best labeled as follows: a) time of assessment/evaluation, b) subject of assessment/evaluation, c) tools/methods used to assess/evaluate. Answers also revealed that those who responded generally considered the practice of assessment to be valuable for their work. As one respondent said, “proper assessment is essential” (t.355,AT).

According to therapists' responses, assessment and/or evaluation is generally performed at one or more stages of therapy: during initial interview, towards the end of therapy and during the course of therapy as an ongoing process. Although it seems that initial assessment session is a common practice of arts therapists, one respondent questioned the validity of such sessions (usually lasting for about an hour) and expressed the need for longer contact with client in order to perform any assessment:

“Only after a number of sessions can one determine if the therapeutic relationship is developing at a healthy pace, and if the client is actually reaping some benefits from participating in Art Therapy.” (t.220,AT)

In addition to planned evaluation times, one therapist mentioned the need to perform on-going assessments in reaction to changing life situations of the clients (like “unpredictable physical illness”). When the therapy is time-limited, evaluation at the end of the therapy by the client becomes especially relevant and needed, as one of the respondent notices (“addressing the endings is always an important part of the therapy” t.133,AT).

Participants' responses also gave insight into ‘what is being assessed’ in the process of arts therapies. Certain topics seem to be in focus at different stages of the therapy and ‘what is being assessed’ corresponds with the time of assessment/evaluation in relation to the whole therapy process. At the beginning of the therapy, specific issues around clients' suitability for arts therapies and their motivation are assessed. In the respondents' words, the “ability to use therapy” by the clients and whether they “feel art therapy will help” and are “prepared to do some hard work” is looked at. Also, only after the potential for developing a real therapeutic relationship is assessed and the important question of “can we work together” is answered, can the therapy begin. The importance of assessing “aims which are achievable for that particular person” or “breaking down what they hope to achieve” as well as “agreement about treatment goals” were stressed. One of the respondents mentions that she/he identifies “with the client up to four major difficulties the client wishes to address during therapy” (t.133,AT). Type of therapy (short or long term, group or individual, etc.) in response to client's needs, should also be agreed at the very beginning. One of the therapists stressed the importance of being aware of the areas of one's expertise and being ready to refer to other services, should the client's needs be outwith the support one can provide. During

the course of therapy, additional issues become core to the therapeutic work and arts therapists continuously assess “whether the therapeutic relationship is developing” and whether the client is actually benefiting from therapy. “Evaluation is an ongoing process” and “progress and improvement” are looked at and any changes are noted, as well as “emerging themes”.

Assessment and evaluation of the therapeutic work are performed through various means and some specific tools commonly used in this process were named by the respondents. Several questionnaires and evaluation systems were mentioned by those therapists, who work within NHS health care system, including: CORE, PHQ9 for depression, GAD7 for anxiety, social phobia scales, work and social adjustment scales. Also, Play and Story Attachment Assessment (PASAA) was reported to be used by dramatherapist working with children, alongside Strengths and Difficulties Questionnaire (SDQ) and Phil Jones’s model. With the exception of PASAA, these tools are not specific to arts therapies but were developed to be used in the practice of other professionals working within mental health or education sectors. “Review of images and symbols” was another evaluative method mentioned, more specific to arts therapies. In addition, “intuitive guidance” and “instinct” were named as having a special place in assessment and evaluation process. One of the respondents also added that they “tend not to assess for Art Therapy per se, but for individual psychotherapy” (t.154,AT).

The lack of tools suited to the evaluation of arts therapies as disciplines distinct from psychology and education, seems apparent from the responses gathered. However, with the small number of answers (n=17) such conclusion should not be generalized to the whole population of arts therapists working with depression. Arts therapists’ interest in developing most suitable ways of assessing is evident in this statement:

“I am hoping to carry out some work based on the sensory potential of materials with dementia clients and an assessment which I’m developing to accompany this, before I retire.” (t.169,AT)

On the other hand, arts therapists’ collaboration with other professionals and within multi-disciplinary teams is apparent and creativeness in the adaptation of existing assessment tools encouraging.

Other specific issues around the theme of assessment included the importance of individual, client-centred approach (“I work very much with the individual and how they wish to work until we find middle ground”), of “the arts therapies to be transparent with participants” and of being “aware of the tendency to be hierarchical in therapeutic relationships to ensure the democracy and equality of the relationship”.

4.2.3.2.4 Summary of Category 1

Arts therapists, who responded to the survey, work in a variety of settings, including the NHS healthcare system, community settings and private organizations. They provide both individual and group therapy of durations and intensity varying between a single session and long term therapy with high level of commitment. The practice seems to be often influenced by guidelines and targets set by health services, which are not necessary in line with therapists’ personal and professional convictions. The respondents’ practice is also influenced by a number of theories with attachment theory and group analysis mentioned most often. Eclectic/integrative approach is often adopted in response to clients’ or settings’ requirements. It is a common practice for arts therapists to include assessment and evaluation in the timeline of the therapeutic process. Among other factors, clients’ suitability to therapy, development of therapeutic relationship and progress/changes are being assessed. A variety of tools is being used for this purpose, often in collaboration with other professionals, with apparent lack of methods designed specifically for the purpose of arts therapies evaluation.

4.2.3.3 Category 2: Characteristics of clients/patients with depression

Arts therapists’ answers enabled insight into their clients’ characteristics, including their major diagnoses or problems and their needs and expectations from the therapy. This category illustrates well how common the problem of depression is and how it is present in a variety of client groups. Also, the nature of depression itself is explored, as perceived by arts therapists, and how the work with this condition differs from the work done with other client groups.

4.2.3.3.1 Client groups

*“Depression is evident in all of my client groups”
(therapist 245, AT)*

Arts therapists’ responses suggest that their clients/patients who suffer from depression do not form a homogeneous group and, for descriptive purposes, it is useful to list other groups, where those clients/patients might belong to (either medically or socially). Please note that the numbers in brackets correspond to the number of occurrences of the specific group in arts therapists’ responses and do not claim to be representative for general population of depression sufferers.

Co-morbidity of depression	Number of occurrences
general mental health problems	12
personality disorder	10
PTSD / trauma	10
anxiety	6
self-harm issues	5
physical conditions (incl. cancer, heart conditions, neurological conditions, chronic pain)	5
learning difficulties	4
schizophrenia	4
dementia	3
eating disorders	3
behavioural difficulties	2
substance dependency	2
high risk issues	2
Asperger’s syndrome	1
brain injury	1
sexual abuse	1

Figure 18: Co-morbidity of depression as identified by respondents.

Although many therapists mentioned (see Figure 18) that their depressed clients came with general mental health problems background (12), they also listed specific prevalent conditions, belonging to mental health spectrum. Among mental health conditions, from which depressed clients suffer, personality disorder (10) and PTSD/trauma (10) are mentioned most often by the respondents, followed by anxiety (6) and self harm issues (5). Other examples include learning difficulties (4), schizophrenia (4), dementia (3), eating disorders (3), Asperger’s syndrome (1), behavioural difficulties (2), brain injury (1)

and sexual abuse (1). Respondents also mentioned working with people characterized as substance dependent (2) and high risk clients (2). Clients with depression also suffer from serious physical conditions (5), including cancer, heart conditions, neurological conditions and chronic pain.

Moreover, the respondents reported that their clients/patients with depression quite often represented specific social groups within the community: families (7), children – including children in care and neglected (6), carers (2), refugees (2), women (2), asylum seekers (1), homeless (1) and offenders (1). The need for such classification most likely suggests that different techniques or tools could be used by the therapists while working with the groups of people with specific needs - not only dictated by depression but largely dependent on other aspects shaping one's life, including social situation.

Arts therapists' responses seem to support the fact that depression is a complex condition affecting people of various backgrounds, ages and lifestyles. They also indicate the most important and prevalent co-morbidity of depression and other disorders and illnesses, including those from both mental and physical health spectrum. This issue will be explored further in section 4.2.3.3.3.

4.2.3.3.2 Main underlying problems

*“Depression both influences and is a result of the complex problems my clients experience.”
(therapist 258, AT)*

The respondents provided especially rich data concerning the underlying problems in depression, the very core of this disorder. They will be explored in this section in order of occurrences (the number of occasions, on which a specific issue was mentioned by the respondents, indicated by numbers in brackets, see Figure 19). For most of these factors it is not possible to clearly define whether they constitute the cause or effect of depression and most of them can be both or neither of those, but rather a visible symptom of the condition (e.g. apathy). Knowledge about specific situation of an individual client might in theory help to distinguish causes from effects, although this may remain difficult even in the course of therapy. As one the respondents noted, depression “both influences and is a result” of complex problems.

Core underlying problems in depression	Number of occurrences
anger (incl. resentment, frustration)	8
social isolation (incl. lack or loosing friendship networks, loneliness)	7
trauma (incl. traumatic deaths)	7
loss and grief (incl. changes of lifestyle and relationships, mourning and death)	7
violence or abuse at home (incl. childhood abuse and neglect)	6
anxiety	6
beliefs about self and the world (incl. seeing oneself as unable to manage challenges of life, seeing the world as dangerous and unwelcoming place and life as meaningless)	6
life circumstances (incl. poverty, homelessness, oppression)	4
emotional pain	3
lack of self esteem (incl. self criticism)	3
medical condition (incl. life limiting or threatening illness)	3
struggle to cope with daily life (incl. inability to make decisions, inability to work)	3
deprivation problems (incl. maternal deprivation)	2
insecure attachment	2
lack of hope (incl. lack of ambition for the future)	2
suicidal ideation	2
vulnerability	2
addiction, ageing process, apathy, defense, dissociation, identity issues, intergenerational patterns, mood changes, rejection, sense of failure, turning inwards, remorse	1

Figure 19: Core underlying problems in depression as named by respondents.

Anger, including resentment and frustration, has been named as an issue most often underlying depression (8). It was described by one of the arts therapists as “a feeling (...) at the heart of depression; unexpressed ancient anger/rage” (t.135,AT). Others said that “depression is covering anger” (t.209,AT) or, in different words, “can mask anger. It also turns anger inwards” (t.218,AT).

Another major problem in the very heart of depression has been named ‘social isolation’ by the researcher to include issues touched upon by the therapists, such as lack or loosing of friendship networks and loneliness (7). It is apparent that social isolation remains the problem of various groups of clients with depression (respondents mentioned dementia patients, personality disorder sufferers, young people, children and refugees).

According to the responses, clients/patients with depression have often suffered trauma in their past (7) in relation to various events, of which childhood abuse and traumatic

deaths were mentioned. Therefore, not surprisingly, 'loss and grief' is another subject appearing often in arts therapists' answers (7); this include significant "losses due to relationship and lifestyle changes" (t.151,AT), grief and mourning with dying being an especially "troubling factor" for the sufferers of depression.

Therapists also claim that violence or abuse at home (most often meaning childhood abuse and neglect) underpins depression in high proportion of their clients (6). Anxiety is another major factor constituting the core of depression (6). Comorbidity of these conditions reaches around 60% in total population of depression sufferers (Hammen & Watkins 2007: 21) According to one of the respondents, often "depression covers underlining and active affective states dominated by anxiety and anger" (t.338,AT). Another therapist said even: "The majority of my clients are anxious and defended and scared." (t.135,AT)

The cognitive aspect of depression with underlying core beliefs about self and "feelings about the world" (6) has also been noted by the therapists, including seeing life as meaningless. One of the respondents described the nature of those beliefs:

"Depression is often tied to a sense of self and a sense of the world. Key elements involve people seeing themselves as unable to manage the challenges of life and seeing the world as a dangerous and unwelcoming place." (t.324,DT)

One respondent recognized that "engaging people in creative works" can be a solution here, as it "pushes back against those beliefs about the self and the world" (t.324,DT).

Life circumstances (4) have also been given a place among issues underlying depression and various "stressors in current life situation" were named by the therapists, to include: poverty, homelessness and oppression.

Furthermore, emotional pain (3), lack of self esteem and self criticism (3) were noted, as well as medical condition (3), including life limiting or threatening illness, which can trigger "unresolved depression". One of the respondents described their experience:

"I have not worked in a specifically mental health setting yet mental health issues are a part of many clients' lives. My main experience has been with dementia, neurorehab and terminal illness. Many clients in each group suffered from depression as well as their medical condition." (t.257,MT)

Struggle to cope with daily life (3), including inability to work, should presumably be treated as a result of depression, but aspects of this concept (like inability to make decisions) may well contribute to the development of this condition.

Deprivation problems (2) (and maternal deprivation specifically) have been commented on by the therapist who works with children: “Maternal deprivation is often central and, and the provision of a maternal object through therapy may become the core of the art therapy.” (t.369,AT) This subject will be explored in more detail, when therapeutic process is discussed (see section 4.2.3.4.2).

Other factors underlying depression mentioned by the respondents include: insecure attachment (2), lack of hope and ambition for the future (2), suicidal ideation (2), general vulnerability (2), addiction (1), ageing process (1), apathy (1), defense (1), dissociation (1), identity issues (1), intergenerational patterns (1), mood changes (1), rejection (1), sense of failure (1), turning inwards (1) and remorse (1).

Such a variety of issues which are associated with the onset or development of depression provides another argument to the discussion around the complexity of this condition. For the purpose of this research it is important to acknowledge that some of the underlying problems in depression seem to be external (e.g. abuse, life circumstances), while others internal to its sufferer (e.g. grief, anger).

A conclusion may follow that some of those issues are more likely to change thanks to therapy, while others may not be amendable. Moreover, the complexity of these problems mean that they may not all be successfully addressed by one clinical approach but rather certain issues may be best tackled by specific interventions. These findings seem to contribute to the common discussion on whether a holistic approach or the one which addresses specific symptoms is more likely to be effective in the psychotherapeutic work with depression (Llewellyn-Jones & Donnelly 2000; La Torre 2000). Nevertheless, noting what constitutes depression is by no doubts important for those who may be able to relate to the opinion of one respondent, who said: “I have found it helpful to see depression in context.” (t.163,AT)

4.2.3.3.3 Nature of depression

*“Depression can mask anger. It also turns anger inwards,
and involves self criticism and rejection.”
(therapist 218, AT)*

Many of arts therapists’ responses concerned the nature of depression itself and provided an insight into what it means to be depressed and what kind of condition this is or at least how it is understood within arts therapies environments. The definition of depression, including its types, will be provided below, as seen from the perspective of arts therapies practitioners. Furthermore, certain aspects of depression will be discussed, which were considered particularly significant by the respondents in their clinical experience.

a) General characteristics of depression

The complexity of depression is often commented on by arts therapists and is best reflected in their responses regarding its definitions, which incorporate medical, social and emotional aspects of this condition.

One of the respondents felt that the concept of depression is “often determined by psychiatric/medical criteria” (t.67,AT), while another states that depression can be defined in a number of ways: “as a diagnostic category, as a universal feeling/mood, a state related to loss or deprivation or as a challenge within treatment to face and work through” (t.86,AT). Other definitions present in arts therapists’ comments accentuate the emotional and psychological aspect of depression, like in this example: “Depression can mask anger. It also turns anger inwards, and involves self criticism and rejection.” (t.218,AT)

One of the therapists notes that “social and political factors” in depression (such as oppression and inequality) should not be ignored, while another respondent notices that social misunderstanding of depression is common (“young people feel it is not a proper illness that family understand, [they] expect them to get on with things” t.62,AT). The social aspect of depression is also present in the following definition:

“I do not consider ‘depression’ to be an entity or specific illness; rather I see it as being socially constructed out of a range of factors and as unique to each person who considers themselves to be suffering from ‘it’.” (t.154,AT)

Metaphors, generally widely valued by arts therapists in their practice, were also, not surprisingly, used by the respondents to depict the nature of depression. One therapist defined it as a “trapped fire energy” and pictured therapy as a means to release it.

Diagnosis of depression appears to be far from straightforward process and arts therapists often state that depression may not be “the primary reason for referral” or “primary diagnosis but can be the dominant symptom” (t.141,AT). The respondents believe that they often work with depression, which has not been officially diagnosed. One of them, who works in an acute ward, stated that “many patients are depressed, but it is unlikely that this is the reason for their admission” (t.32,DMP), while another therapist, who works with children, added: “none of my clients have been formally diagnosed with depression, however, depression is often a symptom of their emotional issues or life circumstances” (t.386,AT). Generally, many of the respondents seem to agree that in many of their clients “presenting problem is often not described as depression, but there are depressive aspects within the complexity” (t.203,AT).

Various terms were used by the arts therapists to describe the type of depression they most often work with, including: chronic, endemic, clinical, reactive and unresolved. The respondents also work with Post Natal Depression (also Postpartum Depression), which was classified by one of the therapists as belonging to “parental depression”. Some therapists mention that they work with Bipolar disorder, which is not in direct focus of this study, being an even more complex condition and including psychotic episodes alongside periods of major or “straight” depression. Long-term depression in older clients was described by one of the therapists as “highly resistant to treatment”.

b) Co-morbidity

At least 28 references were made to the co-morbidity of depression and other mental health conditions, which were listed in more detail in section 4.2.3.3.1. Many of the respondents seem to agree that often “depression is part of other mental health difficulties”, while in some clients “it is the main presentation”. One of the therapists notices that “in a large number of cases depression is covering anger, resentment and appears as one of the symptomatic features of [other] diagnoses” (t.209,AT) while another summarises that “depression is a comorbidity of most mental disorders, apart

from being a severe mental disorder in its own right.” Another respondent even says: “Depression is evident in all of my client groups”.

Relation of depression to the negative symptoms in psychosis was noted and the role of arts therapies in tackling this issue was commented on: “It is this area of difficulty I think art psychotherapy can be particularly helpful in.” (t.80,AT) Evident presentation of depression (“often apparent but not the main pathology”) in the survivors of genocide, torture, trafficking and rape was also noted.

Interestingly, depression and its co-morbidity was given a slightly positive outlook by one of the therapists, who states: “most people agree that regardless of the service users’ diagnoses the thing that binds people together is the experience of depression” (t.159,AT). Therefore, quite paradoxically, depression may force clients to both withdrawal or isolation and connection to others.

c) Complexity

Another aspect of depression, often pointed to by the participants, is its complexity, which is apparent in the causes of depression (“the roots are often complex”), in its process and its effects. One of the respondents noticed: “Depression both influences and is a result of the complex problems my clients experience” (t.258,AT). Another therapist added that “depression serves different functions for each client and can have many layers” (t.123,AT). Furthermore, it is “complicated by other factors including poverty, intergenerational patterns of poor attachments and addiction” (t.71,AT). In result, with its many layers and complexity, depression can have quite different presentations in individuals affected by it and, as one of the respondents states, in order to understand it, it may be helpful (or indeed essential) “to see depression in context”.

d) Severity of depression

The respondents often work with depression which varies in intensity between their clients and within individuals at different points in time; it is described as “a volatile condition, which could within one individual be described as mild, moderate and severe at different times within a variety of time spectrum from hours upwards” (t.51,AT).

Generally, arts therapists describe the level of depression in their clients as mild, moderate and severe or a combination of these:

“some patients have severe depression with suicidal thoughts; some have more moderate depression, but are unable to work or make decisions about their future; some have more mild depression that is treated medically” (t.180,AT)

One of the respondents states that in her/his private practice there is “not enough access to multidisciplinary working to contain severely depressed patients.” (t.180,AT) Two of the respondents expressed their discontent with the expectation to determine the severity of depression in their clients (item 27a, see Appendix 1) and acknowledged that this can be done both “diagnostically and subjectively”. What seems particularly significant for the provision of arts therapies is that clients affected by depression of different severity “vary in their use of art in [art] therapy, the more severe seeming more afraid of using art as it opens processes that are deregulating” (t.180,AT).

e) Summary

Depression, as it appears in arts therapists’ comments, is extremely common and complex condition, very often co-morbid with other mental health and physical disorders, which can only be defined through its many aspects, including medical, social and emotional components. Varying levels of intensity and different types of depression contribute to its complex presentation and, as a result, complex therapeutic needs, requiring flexibility and vast knowledge from therapists. Furthermore, clients who experience depressive symptoms are often diagnosed with other conditions and not depression itself, making it difficult for them to access appropriate care. Co-morbidity, complexity and severity were the aspects of depression given a particular significance by the therapists and therefore constitute the main sub-themes in the discussed theme of the nature of depression.

4.2.3.3.4 Summary of Category 2

People who suffer from depression do not form a homogenous group, but rather significantly differ among themselves in terms of their main difficulties, roots of their

condition and its various presentations. A variety of underlying problems in depression (its causes and effects, often intertwined) include, among others: anger, social isolation, trauma, loss and grief, violence, anxiety and beliefs about the world and self. Depression affects people of different ages and social situations and seems to be linked to a wide range of other conditions, both physical (e.g. cancer, heart condition, chronic pain) and mental (e.g. personality disorders, PTSD, anxiety, schizophrenia, dementia). In addition, the complex nature of depression is often enhanced by its comorbidity with other conditions and varying degrees of severity. Therefore, it may be assumed at this point that arts therapists' work with depression takes various forms depending on the prevailing needs of their specific client group among the sufferers of depression, which will be explored further in section 4.2.3.5.3.

4.2.3.4 Category 3: Working with depression

The problem of working with depression specifically is of a particular interest to this research. The respondents provided rich data, from which several themes emerged that allow for a more insightful description of how arts therapists work with depression, what tools they use and which specific areas of clients' lives can be improved through therapy. Eventually, the role and nature of therapeutic process is more closely looked at, where specific sub-themes emerge, to later guide the development of a treatment manual to be used in phase 2 of this research (see section 4.2.4.2).

4.2.3.4.1 Tools used in therapy

*“using art materials within a therapeutic relationship
can begin to give form to the formless”
(therapist 97, AT)*

Although the participants were not asked directly about interventions or techniques, some of them chose to comment on the tools they use in therapy. These methods will now be presented. It is important to remember that this is by no means an exhaustive list, but rather a few examples of methods that some of arts therapists find helpful when working with depression and especially at the initial stage of therapy, to facilitate engagement and increase motivation.

One of the respondents with experience of working in several day centres for people with mental health problems, including depression, mentioned that “song writing has proved very effective in facilitating motivation to engage with therapy”. Another therapist stated that “body work, although initially difficult, can help to connect, motivate and work with energy” (t.65,other). Writing was also recognised as a helpful tool by the same respondent. One of the music therapists noted that specific methods contributed to building trust and development of the therapeutic relationship, presumably in early stages of therapy, including “encouraging interaction with instruments” and “listening to pre-recorded music of the client’s choice”. Another respondent, an art therapist, acknowledged the value of a visible outcome in the form of images for this particular client group. She/he added that such images provided “an evidence of a unique person/life process/journey and are encouraging” (t.116,AT). The value of “tactile and sensory aspects of materials” for clients with depression, and particularly those who self harm, was noted by another art therapist.

More generally speaking, the respondents seem to agree that “engaging people in creative works” is beneficial on many levels and is the core of every arts therapy intervention, although specific tools and methods used may differ between modalities of therapy and in work with individuals, depending on particular needs of clients and aims of therapy.

4.2.3.4.2 Therapeutic process

*“Working with different ways of exploring, connecting to and gaining awareness of depression, exploring connected belief systems, picking up what’s ‘right’ about going down, all are different ways of exploring the quality of depression.”
(therapist 97, AT)*

What happens in the therapy process and how the positive change is facilitated has become an important factor in arts therapists’ responses; an understanding of this process is an important aim of the current study. Various aspects of therapeutic process were discussed by the respondents, including phenomena generally common in psychotherapeutic practice as well as concepts of a specific significance in the treatment of depression through arts therapies.

a) Challenges

The respondents admitted on several occasions that working with depression can be a challenging experience for both the client and the therapist. First of all, while acceptance of being depressed is needed for a proper engagement in therapy, clients often “struggle to define their mental state as depressed” (t.379,DT) and “it takes some time for them to be able to accept that they are depressed” (t.153,AT).

Therapists, on the other hand, are challenged by their clients’ irresponsiveness (“This client group can be very difficult to engage” t.175,AT) and by the difficulty with addressing depression directly, while it is often correlated with other conditions. Focusing on specific symptoms, not necessarily within the complexity of depression, was suggested as a solution by one of the therapists:

“the best approach is to go ‘round the side’ of depression, by for example enabling the client to have better self-esteem or to manage their anxiety better, and have a more fulfilling life”. (t.57,AT)

Working with depression can also be emotionally demanding for therapists (“It is draining” t.181,AT). Two of the respondents shared that they had experienced depression themselves, although it was not clear whether the depression occurred in response to them working with this condition or in no connection to their practice.

b) Time

Time seems to be one of the main factors influencing the process and the treatment of depression. Arts therapists generally agree that in order to achieve successful outcomes, a longer term approach to therapy is normally required (see also section 4.2.3.2.1). The capacity of arts therapies to reach to the psychological core of the problem in order to efficiently address it and prevent relapses seems especially valued by the respondents. Usually, using the words of one therapist, “it can take time to fully resolve the underlying issues so that the client is less likely to be incapacitated by depression in the future” (t.221,AT). The same respondent occasionally offers short-term therapy to individual patients, which

“does not offer people treatment to work through, resolve their problems, but can support people to think about how to get back on their feet and consider different ways they could approach their longer-term recovery.” (t.256,MT)

One therapist also mentioned that “people at the start of their depressive state are easier to bring to complete recovery” (t.225,AT), while long-term depression can be “highly resistant to treatment”. Time, therefore, seems to be one of the deciding factors of the successful treatment, for which both length of depression and length of therapy are significant.

c) Motivation

As mentioned above, clients’ irresponsiveness may present a challenge for the therapist. Same is applicable to the generally low levels or lack of motivation in people, who are in a state of depression (“motivation is a major factor”). One of the therapist’s main roles, especially at the beginning of the therapy, may involve encouragement and facilitation of motivation to change. Therapists may consider certain techniques which focus on this initial therapeutic task (e.g. “song writing has proved very effective in facilitating motivation to engage with therapy” t.61,MT). Another respondent stated: “The first hurdle is to encourage people to come and participate in a session. When they do attend they mostly find it helpful.” (t.169,AT) Therefore, work on motivation may prove crucial for the eventual success of therapy.

d) Reconnecting

It has been previously mentioned that depression may rightfully be associated with withdrawal, disconnection and isolation, whether it is from other people or from activities, which used to be enjoyed (see section 4.2.3.3.3). Therefore, one of the therapeutic processes, especially important in the work with depression, seems to be “reconnecting to self, others and to what can bring joy” (t.65,other). In response to client’s disconnection, a tendency was recognised by one of the therapists to “focus on understanding and thinking about ways of relating and interacting with others and the self” (t.127,AT). Re-discovering joy (and allowing oneself to do this) constitutes another aspect of reconnecting. As one of the respondents noticed:

“There is a need to facilitate development of pleasurable experiences, [art] therapy can provide this. Finding pleasure in something again can provide new meaning in a life that is stated as being meaningless by clients sometimes.” (t.325,AT)

e) Desired state

Interestingly, some therapists mention in the survey that depression is somehow a desired state to certain extent, which in the process of therapy comes after initial work has been done as an effect of still painful insight, which can be later worked on towards acceptance. Related point was raised by Ghaemi (2003), who describes the “depressive realism” model, where depression correlates with an increased insight or “seeing the world too much as it is, with all its pain and mortality and with all our weakness and cosmic insignificance as individuals” (Ghaemi 2003: 240). It may also be argued that more severe depressions may lack insight, which needs to be gained in order to progress through milder forms of depression towards psychological maturity.

Melanie Klein’s concept of depressive position (Klein & Mitchell 1991), an important and desired developmental stage of maturity characterised by an ability to accept oppositions (following paranoid/schizoid position), seems to have influenced some of the therapists’ thinking. According to the respondents, the concept is especially relevant to particular groups of clients, specifically to those with co-morbid conditions. One art therapist comments on his/her team’s practice with clients diagnosed with personality disorder: “It could be said that we focus on helping people to get depressed rather than attempt to avoid the feelings by acting out” t.178,AT (by self-harming, for example).

Another therapist admits that “depression often comes as a secondary process after further work because they [clients] have (in general) developed the capacity to ‘think’ and move toward looking at their anger” (t.135,AT), while another respondent felt “that many offenders’ behaviour is a defence against depression” (t.342,AT). In this context, depression becomes almost a positive stage, a necessary (however painful) state of transition towards improved well-being and self-awareness.

f) Corrective re-parenting

While building trust and relationship between a client and a therapist is a key factor in every psychotherapeutic situation, it seems to have a specific significance in the context of the treatment of depression. According to one respondent, the therapeutic relationship may take the form of “a ‘corrective re-parenting’ which can help alter the client’s perception of him/herself and his/her world, and making depression redundant and unnecessary” (t.57,AT). Successful re-parenting may be supported by the provision of a maternal object, which, in another therapist’s words, is “often central and (...) may become the core of the [art] therapy” (t.369,AT). Such thinking seems to have been clearly influenced by the object relations theory (Greenberg & Mitchell 1983).

g) Other aspects of therapeutic process

Other concepts, generally present in psychotherapeutic process, were also recognised by arts therapists. The importance of clear boundaries was noted (“boundaries and what belongs with whom are key issues” t.221,AT) and the concept of holding was commented on (“very often there is a ‘holding’ of the depression, while a journey from darkness to light unfolds”).

Containment was also considered “extremely important”, while “it is healing to know that someone understands what you are trying to communicate, or that someone is trying to understand” (t.245,AT). In this light, the therapy space has been described by one respondent as “a place for feeling safe, held and contained”, especially when “the environment has failed” to provide that.

Holistic approach to the process of therapy was also visible through some of the responses with one dramatherapist stating that “it is very important to engage [clients] on the body as well as the mind level” (t.264,DT). While general psychotherapeutic principles seemed mostly valued by arts therapists, it was recognised that medical input may be helpful in the therapy process, especially in its first stages, as one of respondents noted: “medication may be used to alleviate symptoms and enable the client to work with me” (t.120,AT).

h) Summary

For the meaningful and effective therapeutic process to develop, the aforementioned concepts may potentially be considered by the therapist, with a special attention given to those factors, which are most likely to affect the work with depression. Challenges of such practice should be acknowledged by the therapist and issues around time, motivation, reconnecting, 'desired state' and re-parenting may be considered. Other aspects of therapeutic process (containment, therapeutic relationship, boundaries, holding, etc.) may not be specific to the practice of arts therapies or to the treatment of depression. They, however, help to position arts therapies practice within a wider context of psychotherapeutic interventions by the recognition of similar principles.

4.2.3.4.3 Benefits of arts therapies

*“[art] therapy helps foster a greater sense of self, personal choice, mourn losses due to relationship and lifestyle changes, address anger, provide time for oneself, all of which affect mood and depression”
(therapist 151, AT)*

Arts therapists seem to recognise the value of their practice, as a variety of positively charged adjectives were used to describe therapy they offer, including: beneficial, effective, helpful, useful and successful. One of the respondents said that arts therapy “is excellent in its ability to reveal and process underlying causes of depression to all levels of intensity” (t.138,AT). Moreover, the therapists commented vastly on observed effects of their practice in depressed clients and gave examples of areas which could be improved through arts therapies. Several recurring themes emerged including: better functioning, well-being, gaining meaning, reconnecting, self-esteem, self-expression and sense of self. Each of these concepts will now be looked at more closely.

Firstly, arts therapies are described by the respondents as capable of meeting some of the basic needs of the clients who suffer from depression. According to the respondents, their clients need to “express how they are and to be seen/heard” and to “tell their story and have it witnessed”, both of which could be achieved through arts therapies.

The respondents have noticed that arts therapies seem to enhance general functioning, by developing new emotional resources, helping to build coping skills and improving concentration. One of the therapists added that short-term group therapy within NHS service for people recovering from an acute phase of mental illness “can support people to think about how to get back on their feet” (t.256,MT).

Better functioning is observed by therapists alongside better well-being. It was noted that arts therapies can help with regaining a sense of hope and optimism and can lead to stress reduction. The therapy is also seen as enabling a “more fulfilling life” or, in other words, “enhancing life” through creativity.

Finding a meaning in life was identified by three therapists as the effect of therapy, while one of these respondents stated: “working with creative processes has been beneficial in terms of giving some meaning to one’s existence.” (t.364,DT)

Other mentioned benefits of arts therapies oscillated around the theme of relating, interacting or “reconnecting to self and others”. This seems to be seen by therapists as crucial and possible as therapy “reduces isolation”.

Respondents also reported that a therapeutic relationship offered through arts therapies “builds trust, confidence and self-esteem”. “Sense of self belief” and “personal choice”, mentioned by some respondents, seem to be linked to the idea of general self-esteem being fostered. Although arts therapy is not directly a learning experience, one of the therapists mentioned that the therapy she/he offered “can facilitate a sense of learning a craft and this can promote a sense of mastery which clients state bolsters self-esteem” (t.325,AT).

Moreover, arts therapies are believed to be beneficial by “enabling participants to find emotional expression for their experience” (t.152,AT) or helping to “give a tangible form to their emotional experiences” or else, allowing them “to express how they are, and to be seen/heard”. One of the respondents commented on “oppressive qualities within depression” and sees therapeutic process as central for “getting to know and then letting go of the oppressive feelings” (t.97,AT), including “mourning losses due to relationship or lifestyle changes” (t.151,AT). The opportunity for self-expression through creativity seems to be especially valued by the therapists and unique to arts therapies. One respondent explained why she/he considered such expression crucial for recovery:

“I see many adults (...), who have not got in touch with their creative selves and therefore are starved of creative expression - this often has caused emotional blockages (...) in certain areas that should be free flowing.” (t.298, other)

Achieving or regaining the ‘sense of self’ was identified by three arts therapists as another benefit of their therapy, particularly meaningful for depression sufferers. Two other responses seem to be linked to this idea: one of them stating that ‘corrective re-parenting’ within therapeutic relationship “helps alter the client’s perception of him/herself and his/her world”, while another respondent says that her/his work, by offering opportunities for self-expression, contributes to the clients’ “greater understanding of themselves”.

4.2.3.4.4 Summary of Category 3

Arts therapists’ responses suggest that while working with depression is a complex and challenging process (as is depression itself), it often has specific benefits for the client, including enhancement of creativity, improvement of well-being, regaining of confidence and re-discovering of meaning and the sense of self. The desired therapeutic process requires that main aspects of general psychotherapeutic interventions are present (e.g. relationship, containment), with which there seems to be an agreement among respondents. In addition, the nature of depression dictates that certain themes are most likely to be explored during the course of therapy (e.g. reconnection, motivation, re-parenting) and specific tools may be helpful in achieving therapeutic aims.

4.2.3.5 Furthering understanding: Depression-specific survey

A depression-specific survey followed the main Survey in order to increase the already created opportunities for gaining understanding of the nature of arts therapists’ work with depression even further. As previously mentioned in section 3.3.5.2, seven therapists (five art therapists, a systemic psychotherapist and a group analyst) completed the specifically qualitative survey, offering detailed and insightful comments on their own practice. This section presents the most significant information and conclusions derived from those responses.

4.2.3.5.1 Characteristics of clients

Arts therapists were asked about main characteristics of their clients and their responses relate well to the findings from the main survey. “Variety” seems to be the one theme here, whether it concerns co-morbidities often present alongside depression (e.g. schizophrenia, Bi-polar, psychosis, anxiety disorders, OCD, substance misuse, relational difficulties, attachment issues, medical problems), different social groups affected by depression (e.g. carers, refugees, people in isolation, parents) or referrals coming from various settings (e.g. multidisciplinary teams, mental health services, psychiatrists, GPs, social workers, self-referrals).

The results support the previous finding that people suffering from depression do not form a homogeneous group and the diversity within it makes it extremely challenging to even provide consistent definition, not to mention universal solutions. Whenever therapists mentioned the average age of their clients, this was always labelled as ‘adults’ and fell between 18-65, with only one person mentioning working with adolescents alongside adults.

4.2.3.5.2 Theoretical influences

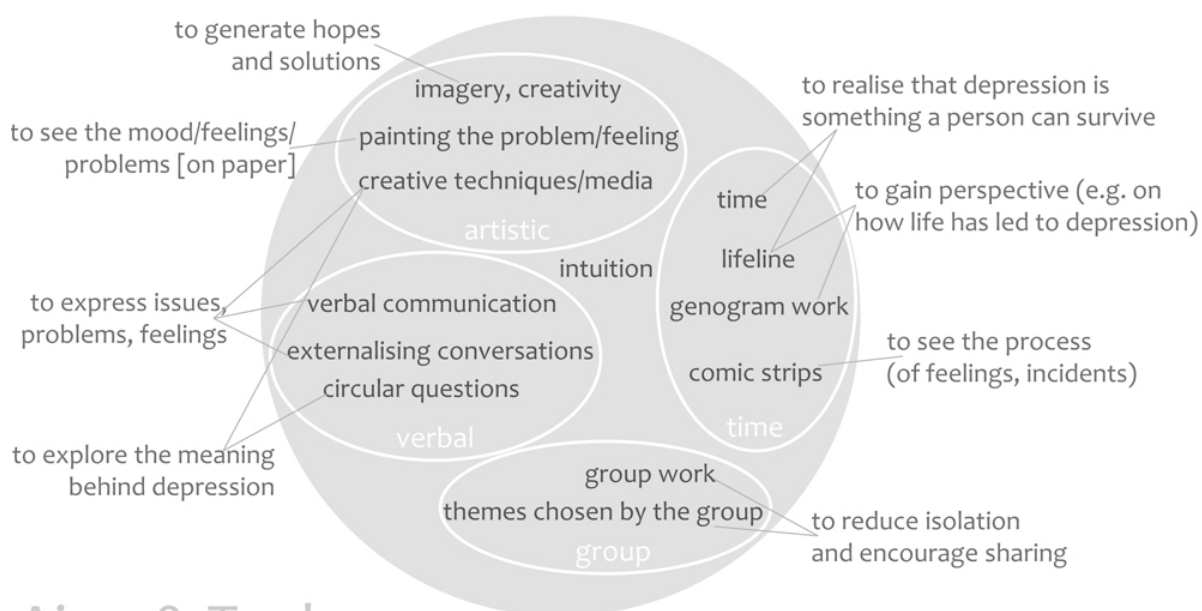
Asked to name the strongest theoretical influences, therapists again provided a variety of approaches, which could best be labelled with one of the respondents’ expression – an “eclectic mix” (t.3). Approaches mentioned by the therapists include: psychodynamic, systemic, narrative, cognitive, humanistic, person-centred, solution-focused, directive, intercultural, interpersonal, attachment theory, object relations, CBT and mentalization. One of the respondents stated that she/he successfully combined creative and cognitive techniques in her/his practice and said that “both approaches complement each other” (t.1).

The responses support the notion from the results from the main survey that arts therapists’ practice is often influenced by very different theoretical backgrounds and that most of the therapists choose not to limit themselves to practising within a certain theoretical paradigm, but rather take from a variety of approaches and mix them accordingly to clients’ needs and own preferences.

4.2.3.5.3 Aims and interventions / tools

Many of the therapists' responses concerned aims of therapy which they offer to adults suffering from depression. Specific tools and interventions were usually mentioned in the context of these aims. A comprehensive analysis of relations between these concepts revealed a matrix of ideas, which have been successfully implemented by the therapists in their work with depression.

It became apparent that the interventions used by arts therapists can be grouped into four main clusters of tools: artistic, verbal, group and time related. Some therapeutic aims seem to be best addressed by tools belonging to certain categories, while others may be explored through the use of various techniques. The image below (Figure 20) visually illustrates those relationships.



Aims & Tools identified by arts therapists as useful in their work with depression

Figure 20: Aims and tools identified by arts therapists, who work primarily with depression, as helpful in their practice.

Arts-related tools were identified by the therapists as useful in the expression of problems and emotions and exploration of the meaning of depression. In addition, creativity offers a chance to look at problems or disturbing feelings from a perspective and often literally (e.g. "see the mood on paper" t.7). As one of the therapist stated,

“working with images provides a concrete version of the condition thus beginning the process of recognising its power, exploring way to take control of [it]” (t.1). It was also mentioned that imagery and creativity may help in “positive generation of hopes and solutions” (t.5).

Verbal aspect of therapeutic intervention seems to be valued by the therapists, who suggest that both expression and exploration of the problem may be enhanced by verbal communication. Specific techniques, coming from certain psychotherapeutic models, were mentioned, including circular questions (Fleuridas et al. 1986), characteristic for systemic therapy, and externalising conversation (Stacey & Hills 2001) – a concept derived from narrative therapy tradition.

Group work, and specifically working with themes chosen by the group, was also mentioned to be beneficial to those suffering from depression by “reducing isolation and encouraging sharing” (t.6).

Another set of interventions may be clustered around the theme of time. The same concept seemed significantly important in the findings from the main survey (see section 4.2.3.4.2). Some tools mentioned by the therapists make use of time to allow for a gained “perspective on how life has led to depression” t.3 (lifeline and genogram work) or visualisation of “the process of feelings and incidents” (comic strips). Looking more closely at the issues around time seems to bring realisation that depression is not eternal and may be fought (“to see times past and be able to realise that depression is something a person can survive” t.7).

One of the therapists mentioned intuition as a tool used in her/his practice and, since the same concept appeared in the statements from the main survey, it seemed important to include it in the matrix of interventions. Another therapist added that “realistic goals” are crucial in setting up the therapeutic situation and, while not an intervention in itself, it seems relevant to mention it here, as part of therapeutic process.

It should be stressed here that the aims and tools mentioned in this section do not by any means constitute a comprehensive list and resulted solely from the responses of seven arts therapists. This list is not intended for use on its own, but should rather be regarded as part of a bigger picture, which should include available clinical literature and data from other studies. Nonetheless, this is a rare collection of techniques coming

directly from therapists who work with depression and will later be used as a guide for creation of the treatment manual (see section 4.2.4.2), alongside theoretical and case literature and appropriate guidelines.

4.2.3.5.4 Meaning of depression

In another question, the respondents were asked to describe the meaning of depression for them, as therapists, and not necessarily reflecting commonly known clinical definitions. Statements which followed contained aspects of depression, considered generally known by mental health practitioners and widely mentioned in literature and clinical practice (e.g. psychological and biological symptoms: low mood, low self esteem, withdrawal, problems with sleep, etc.) as well as some creative expressions reflecting the feeling of being depressed.

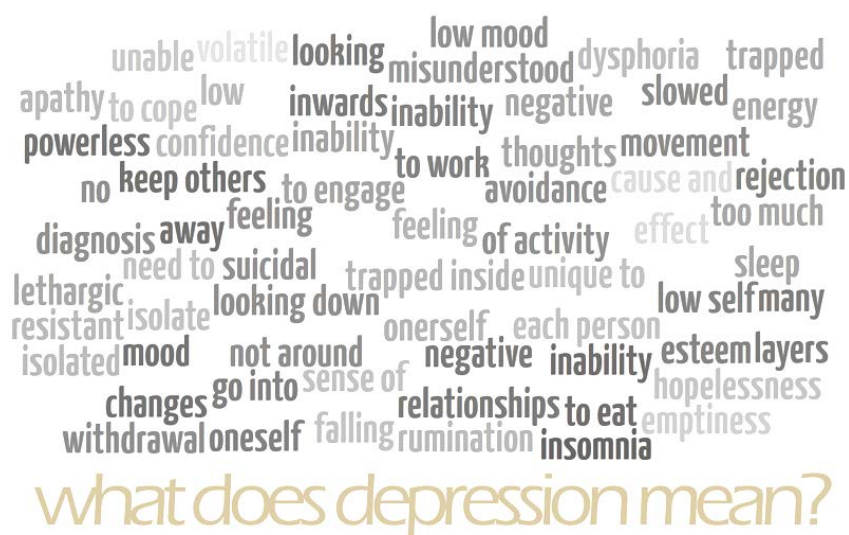


Figure 21: Word cloud illustrating arts therapists' responses to the question: 'What does depression mean to you as therapist?'

Interesting comments included physical presentation of depression and therapists mentioned that the movement is usually slowed and people affected "look down not around them when thinking" (t.4). Some of the aspects of depression which were mentioned may affect arts therapists' work with this client group, especially when therapy is provided to a group. Such features include "inability to engage in meaningful activity" t.3 (or even "avoidance of normal activity" t.5), "need to isolate" t.7 and "keep

others away from this” t.7, feeling of being “trapped inside yourself” t.1 (One respondent similarly stated that a person is depressed when they “go into themselves” t.4). These comments seem to well illustrate one of the paradoxes of depression: the need to relate and engage versus the avoidance of others and tendency to isolation. Also, the therapists comments seem to support the finding from the main survey (and from literature) that motivation (or rather: lack of it) is one of the most challenging aspects of depression and they additionally explain possible reasons for the inability to engage. All features of depression mentioned by the therapists have been included in the word cloud above (Figure 21).

Actual subjective and personal definitions of depression were also provided by the therapists. Some of the expressions used included: “a stuck place”, “a grey world”, “a habit of mind” or “a personalised condition, (...) difficult to verbalise”. Figure 22 illustrates the designations of depression used by the respondents.

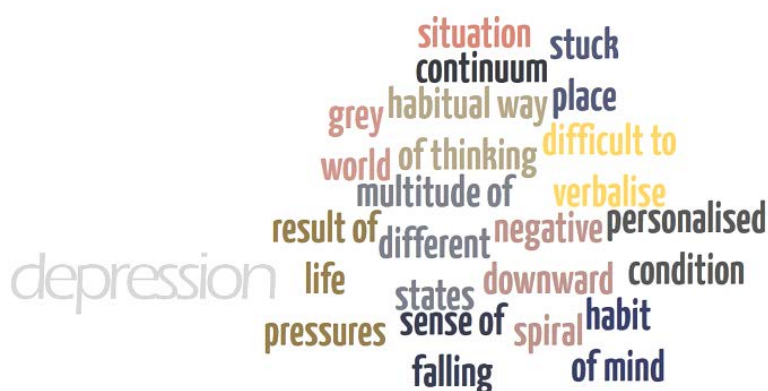


Figure 22: Word cloud illustrating arts therapists' definitions/designations of depression.

One of the responses reads: “Emptiness, endlessness, oh no - not again - a sense of falling. Feeling that you’ll be terrible company, toxic, need to isolate and keep others away from this.” (t.7) This definition, or rather artistic impression of what it means to be depressed, convincingly illustrates the mechanism of vicious cycle, the repeatedness and hopelessness of depression, together with the feelings of guilt and not being worth the attention of others.

Helping the client to get out of the “stuckness”, to break the vicious cycle of disengagement and isolation, to accept support and to open for others around may present one of the most significant aims in therapy of depressed adults and arts therapies, especially in groups, may provide useful tools. While creativity promotes openness, it encourages sharing and helps to accept presence of other people in the process of recovery. One of the therapists mentioned that the “symptomatic imagery often comes in the form of black shapes, spaces and dread” (t.5). Metaphorically and literally, creativity could promote the introduction of colour.

4.2.3.5.5 Challenges and rewards

The respondents made relatively lengthy comments on the challenges and rewards of working with depression.

The therapists generally feel that a change in this client group is often difficult and sometimes impossible to achieve and clients’ responsiveness to therapy may be low (working with depression is “somewhat intractable”). While possible, recovery from depression is a “slow process”, where it is “hard to catch positive change”. Lack of internal personal resources and difficult life situations of the clients were mentioned as reasons for this challenge.

Another problem, which has already appeared in the findings (see section 4.2.3.3.3), seems to be the lack of or low motivation and specific attitude among the long term depressed clients, who often do not believe that improvement is possible (“[they] believe they're just made that way” t.5). This may be a difficult point in which to start therapy and the solution, however not easy to implement, may be “imagining a place when patients were engaged and active, to start with hope, lending hope” (t.5). Lack of motivation to change and tendency to isolate themselves (identified by another respondent) leads clients to difficulties with turning up for sessions.

Other challenges mentioned by the therapists included ineffective communication with other professionals (“not including me in the care plan meetings” t.3) and the way that clients are affected by medication. Two of the therapists have also commented on the difficulties around the provision of psychotherapeutic treatment for depression, which,

they felt, is not considered a priority in comparison to other conditions, which in consequence leads to lack of significant evidence-based and systematic research. While this gap in research and only anecdotal evidence available should only mean that no claims can be made that arts therapies are effective, it is “often taken to mean that there is evidence that they don’t work” (t.3). These interesting statements, which show signs of professional frustration with policy makers not giving enough attention to the treatment and research in depression, are:

“I think that the ‘depression’ diagnosis tends to be lost amongst other diagnostic groups; it is often something that is ignored (ie therapy is not available under NHS) until it develops into something more acute. Offering more therapy for depressives could be a helpful preventative practice.” (t.7)

“I think the reason there are no big research projects (like there have been for schizophrenia) is that people with depression are not seen as a danger – they are quiet and may harm themselves or commit suicide but are very unlikely to harm others (which a few people with schizophrenia do). It seems quite political to me!” (t.3)

The rewards of the therapeutic work with people who are depressed seem to be a reverse of the challenges, at least to some extent. Four of seven therapists mentioned that change is often possible and they see their clients recovering (“often they do make progress” t.3, “the best reward is to see it improve” t.7), regaining “better view of themselves” and able to “take charge of their lives” (t.1). One of the therapists highlighted the importance of appropriate “feedback about changes in patterns outside therapy” (t.6), as an indicator of lasting change while another stated that clients suffering from depression can often assist in the making of good relapse prevention plans (“often people have great resources” t.5). However, one therapist added that a lift in mood often means more challenges on the therapeutic way (“when clients lift, it sometimes seems like a mourning process develops” t.6). The respondents seem to also draw professional satisfaction from clients simply turning up for sessions regularly (“means that they are getting something from it that they need” t.4).

4.2.3.6 Summary of qualitative findings

The findings from qualitative analysis, as expected, provided more depth into the quantitative results and explored areas, which could not be addressed through the use of numbers purely. Additional information about arts therapists and their clients became available, which helps to imagine what the encounter of a therapist and depression sufferer may look like. The realisation of the nature of the therapeutic process, in addition, helps to understand how this relationship may and should develop to bring benefit to the client and professional satisfaction to the therapist.

Generally, in order to address complex needs of depression sufferers, therapists feel that it is most appropriate to employ an “eclectic mix” of approaches and techniques. It is recognised that, while verbal communication, similarly to other psychotherapies, has an important role in therapy, creative expression and communication through arts media adds a valuable dimension to the process and may be especially beneficial to clients with depression by helping them to reconnect to others and feelings, express emotions and generate new hopes and meaning.

While depression is a complex condition, not easy to define and interconnected to other mental and physical disorders, it presents specific challenges in therapy, where the issue of motivation and time as well as the paradox of isolation versus the need to relate become apparent and main themes within the therapeutic process. Arts therapists’ work with depression seems to be both demanding and rewarding, when the client experiences the benefits of therapy and moves from “turning inwards” to reconnection and re-discovered meaning.

4.2.4 Making connections: Integrating Phase 1 and introducing Phase 2

As indicated in the Introduction to this section, integration of all findings from phase 1 of this research will now be attempted. Firstly, connections between the key findings of quantitative and qualitative character will be sought and a brief summary will be offered. Secondly, connection between the two phases of the research will be established and how the findings from phase 1 informed further developments of phase 2 will be explained.

4.2.4.1 Summary of all findings

Phase 1 of this research aimed to increase understanding of how arts therapists work with depression. Following the presentation of all findings, this section now aims to offer meaningful connections and extract the essence of the effects of comprehensive analyses undertaken on quantitative and qualitative findings. Core insights gained in this process will be presented in points, for increased clarity. Please note that the statements should not be removed from the context of this study.

1. Depression seems to be a very common presentation in arts therapies practice, while over 90% arts therapists have clients suffering from the condition and some (17%) declare that they work primarily with depression. Drama and art therapists are more likely to work with the condition than music and dance movement therapists.
2. Arts therapists who work specifically with depression tend to be older and more experienced than those who do not encounter depression in their practice.
3. While arts therapists with particular interest in depression work in a variety of settings (including healthcare, community, voluntary sector, education and private practice) they work in health services most often (as opposed to other therapists who tend to work in educational settings most often). The work setting and its particular guidelines and targets may significantly affect both the quality of work and techniques applied by therapists in their practice and are not necessary in line with therapists' personal and professional convictions.
4. One-to-one is most common therapy mode for all arts therapists, while those who specialise in depression work more often with groups than other therapists. Group work seems to differentiate between arts therapists with varying experience of practice with depression. Both individual and group therapy may be of different durations and intensity varying between a single session and long term therapy with high level of commitment. Although short term therapy (e.g. 12 weeks) is common, many therapists seem to prefer an opportunity to offer

longer term treatment, which allows for more in-depth exploration of the problem.

5. Clients of arts therapists who specialise in depression do not form a homogenous group. They are most often adults or young adults (as opposed to children and adolescents in case of therapists who do not work with depression) and belong to different social groups. Most often, they tend to suffer from other conditions alongside depression, including other mental health problems (e.g. PTSD, personality disorder, anxiety, dementia) or physical conditions (e.g. cancer, heart conditions). Depression is often not a primary diagnosis but a dominant symptom in those clients and arts therapists consider more of their clients depressed than numbers of diagnoses in referrals would suggest.
6. Arts therapists who specialise in depression tend to most often describe their clients' conditions as severe and often as moderate. Working with clients suffering from severe depression may be more challenging, while reluctance to reveal complex underlying problems may be stronger.
7. Depression is a complex condition with causes and effects often intertwined. Main underlying problems in depression listed by therapists include: need to isolate and turning inwards, anger, loss and grief, anxiety, trauma and abuse, beliefs about self and the world. Metaphorical descriptors of depression given by therapists included: stuck place, grey world, habit of mind, emptiness and endlessness.
8. Arts therapists who work primarily with depression are influenced and inspired by an "eclectic mix" of theories, most often originating from general psychotherapy tradition. They indicate humanistic/person-centred, psychoanalytic/psychodynamic and eclectic/integrative approaches as preferable and tend to agree more with psychoanalytic/psychodynamic principles than therapists, who do not work with depression. Other most commonly indicated influences include attachment, developmental, group analysis and object relations theories, specific arts therapies traditions as well as work of Winnicott

and Jung. Eclectic/integrative approach, to work how it feels appropriate, is often adopted in response to the demands of work setting. Often psychological (including cognitive) and creative techniques complement each other, medication is at times considered helpful and holistic approach highlighting body-mind relationship is often preferred.

9. Tools and interventions used by arts therapists in their practice with depression may be grouped into: artistic, verbal, time and group-related. Techniques correspond to the particular therapeutic aims, both general and specific to depression, including: generation of hopes, expressing problems and feelings, exploration of meaning behind depression, increase of connection and sharing, regain of perspective and others. Engagement in creative process is in itself valued as is intuition among the tools.
10. Among therapeutic aspects common in psychotherapy (e.g. therapeutic relationship, boundaries, containment, holding) therapeutic process in the work with depression includes specific areas and themes like: a) time (length of treatment and duration of depression are important); b) motivation (especially the beginning of the therapy may involve encouragement and facilitation of motivation to change, which may be crucial for the eventual success of therapy); c) reconnecting (to self, to others and to joy and what brings pleasure); d) desired state (depression seen as almost a positive and necessary state of transition towards psychological maturity); e) re-parenting (provision of a maternal object, central to therapy). In addition, the paradox of isolation versus the need to relate becomes an apparent and main theme within the therapeutic process.
11. Work with depression presents arts therapists with numerous challenges (incl. low responsiveness and disengagement of clients, perceived need to work with symptoms outwith depression, difficulties around the provision of psychotherapeutic treatment for depression, emotional demands) and rewards (seeing clients recover, take charge of their lives, move from “turning inwards” to reconnection and re-discovered meaning).

12. Potential benefits of arts therapies, as indicated by practitioners, may include: enhancement of creativity and self-expression, improvement of well-being, better functioning, regaining of confidence, reconnecting and re-discovering of meaning and sense of self.

(It should be noted that the listed points offer a brief summary by integrating quantitative and qualitative findings and a more in-depth meaning should be sought by referring to previously given detailed descriptions accompanied by discussion as and when relevant.)

Brief summary:

Arts therapists very often address depression in their practice, even if it has not been recognised as a main diagnosis of their clients. Some arts therapists specialise in the treatment of depression. They often follow humanistic, psychodynamic and integrative theoretical principles, are relatively experienced and established in their practice and tend to work with groups more often than other therapists. They have a good understanding of the nature of depression, including its complex presentation, co-morbidity and varying severity. The tools used in therapy respond directly to the needs of clients and include artistic, verbal, time- and group-related techniques. Therapy process commonly develops around certain themes (e.g. time, motivation, reconnecting). Practice with depression is recognised as beneficial to clients by the therapists and brings numerous challenges alongside professional and personal rewards.

4.2.4.2 Development of a treatment manual

Once Phase 1 of this research was completed and description of arts therapists' practice shaped, Phase 2 could follow to further the investigation by evaluation of this practice in quasi experimental conditions. The intervention needed to be standardised to allow for its most objective assessment and development of a treatment manual immediately followed the completion of Phase 1.

This process was challenging for a lone researcher and it needs to be acknowledged that the final product lacks depth and experience of other professionals and experts in the treatment of depression. While development of treatment manuals or other clinical guidelines often requires input from a team of professionals, who could offer various perspectives, the manual created for the purpose of this project is a modest attempt to standardise the intervention in a pilot study conducted primarily by a single person. The manual is therefore limited in its content and scope. The final document is included as an appendix due to its size (see Appendix 11) and paragraphs below summarise the main principles applied.

In general, the manual was intended to give guidance to both the therapist and the researcher, while preparing, facilitating and reflecting on the interventions to be applied in this project (art therapy and dance movement psychotherapy, later limited to art therapy only, as explained in section 3.4.2.1). By no means did it aim to provide an exhaustive list of tools or activities to be used. Rather, it highlighted the main theoretical underpinnings of the planned interventions, discussed the aims of the therapy in the specific context of adult depression, provided an overview of the expected life of the group, pictured the general structure of each session and suggested exemplary activities.

This treatment manual was developed, based on three main sources of knowledge and experience:

- specialist literature and current research on arts therapies, psychotherapy and depression
- current NHS guidelines for depression (NICE and SIGN) and manuals of arts therapies good practice
- findings from phase 1 of this research (nationwide survey of arts therapists, with 395 responses, of which 294 respondents have people affected by depression among their clients and 67 work with depression specifically)

The document consisted of four sections, each focusing on a different aspect of the intervention and aiming to:

- provide theoretical and expert background of the intervention
- identify therapeutic aims, as relevant to adults suffering from depression
- sketch the general group situation throughout the therapy, as expected in similar groups
- propose the application of specific structure within each session

The four sections were intended to shape the intervention, starting from its therapeutic background, through general ideas of group work to more specific applications in the particular situation of working with depression.

While the treatment manual was developed prior to and in early stages of Phase 2, it needed to offer general suggestions to be applied in a group, regardless of its specifics such as participants' needs or readiness to be involved. Many conditions of the treatment could have been anticipated, based on general knowledge on depression, specifics of group work and arts therapies practice in particular. However, more specific clinical decisions needed to be undertaken only after the participants in this study were known and shared their expectations and needs in initial interview, serving additional role of a clinical assessment. Once interviews/assessments were completed, additional information from individual participants allowed for enhancement of section 2 ("Aims and methods") of the treatment manual. While therapeutic aims anticipated prior to interviews were still applicable to the group, more specific areas of clinical interest emerged.

In order to understand the nature of depression present in the group, main underlying problems were identified and listed. Among issues shared by all or most participants were: difficulties with forming relationships and trusting people, lack of self-confidence, tiredness, lack of motivation, social isolation and loss or bereavement. The complete list is included in Appendix 12. Further analysis of the interviews allowed for a more in depth understanding of the psychological mechanisms responsible for the most common problems identified. Characteristics of participants' usual and unhelpful patterns of cognition, emotion or behaviour were named and counterbalanced by a corresponding

therapeutic aim (e.g. relaxation in response to constant fighting, expression in response to blockage, awareness of others in response to self-consciousness). Appendix 12 includes a complete list of pairs of problems and corresponding therapeutic aims.

Once initial clinical aims were identified, they were shared with the therapist, who did not have a chance to undertake clinical assessment herself. The treatment manual complete with additional aims specific for the group served as a guide for the researcher and the therapist throughout the project. However, it needs to be noted that the development of two last sections of the treatment manual (“Life of the group” and “Session structure”) had not been fully completed before the start of the sessions and therefore the principles included in these sections were shared with the therapist verbally only. It is understood that this fact had some implications on the final shape of the intervention, which will be further discussed and evaluated in section 4.4.6.

4.3 Phase 2: Evaluation of group art therapy for depression

Comprehensive evaluation of group art therapy offered to participants will be based on outcomes originating from several sources of data, both quantitative and qualitative. For increased clarity, they will now be presented separately before an attempt is made to offer a consistent final evaluation. Qualitative findings coming mostly from interviews with participants will be presented first and followed by findings originating from participant observation and arts-based reflection, to be concluded with quantitative analysis of the outcomes. Finally, integration of findings from multimodal data sources will be attempted to offer consistent and meaningful evaluation.

4.3.1 Introduction

An art therapy group was facilitated in February/March 2013, with five participants suffering from mild and moderate depression. The treatment eventually consisted of 9 sessions, offered twice weekly, on Wednesdays and Fridays afternoons.

The therapy was facilitated by a qualified art therapist, who met with the researcher on three occasions prior to the beginning of the group and participated in shaping of the intervention, eventually based on the treatment manual and the therapist's experience and skills. The therapist and the researcher used half an hour before and after most sessions to discuss useful interventions and contemplate on the progress of therapy. During the sessions, the researcher was inactive and clinical decisions were made by the therapist alone. In addition to regular contacts with the researcher, the therapist was in usual clinical supervision for the duration of the project.

The group consisted of female and male participants, whose age ranged from 32 to 65. All five participants completed the full course of treatment, with an overall attendance rate of 87% (see section 4.4.2 for more details). Also, all five participants attended initial, final and follow-up interviews in person and completed the set of questionnaires, with an exemption of one occasion when a participant missed her/his follow-up interview but agreed to communicate via email.

In order to protect participants' identities, either aggregated data or individual data with no age or gender labels attached will be presented in the following sections. Where

information about personal background especially enriches the analysis, every care will be taken to ensure anonymity and any specific or unusual data will be generalised, as needed. Whenever findings concern individual participants, neither their age nor gender will be disclosed and the form of “she/he” will be used.

4.3.2 Participants’ evaluation of the experience of art therapy: Outcomes from initial, final and follow-up interviews

Participants took part in three interviews, each serving different aims of both clinical and research significance. Initial interview (prior to therapy) intended to assess participants’ suitability for treatment and establish areas of personal difficulties to be targeted in the process of therapy. It also focused on expectations of therapy. In a final interview (immediately after the course of therapy) participants’ current psychological state was again assessed and options for future actions regarding treatment were explored. The researcher also prompted participants to evaluate their own experience of received therapy and encouraged comments on any aspect of the research and/or therapy process. Finally, follow-up interviews were less structured and once again offered participants a chance to share any other thoughts on their therapy or the project from the perspective of the time passed (between 10 and 11 weeks).

Initial and final interviews were recorded, while in follow-up interviews notes were taken as needed. The data was then gathered and themes were sought in the questions asked as well as in participants’ responses not necessarily associated with specific question. The findings resulted in a series of themes, which will now be presented.

4.3.2.1 Themes from initial interviews: current situation and expectations of therapy

Initial interviews provided rich clinical and research data. However, a sufficient clinical assessment, enabling a decision whether a potential participant is a suitable candidate for the group art therapy, was a priority here. Themes presented below, although more relevant to clinical practice, are believed to be useful for the research process, as they enable a more thorough understanding of the nature of depression and of the origin of the previously discussed (see sections 3.4.5.1 and 4.2.4.2) therapeutic aims in this

project. Eventually, the findings illustrate participants' experience with arts and psychotherapy and their expectations and hopes on the onset of art therapy group.

4.3.2.1.1 Nature of depression in the group

Initial interviews aimed to identify what the nature of participants' depression was. This seemed crucial for two reasons: 1) for establishing of therapeutic aims (clinical aim) and 2) for enabling better understanding of the depression present in the study sample (research aim). These characteristics of depression, as reported by the participants, will now be presented. When a particular feature was mentioned by more than one participant, this will be indicated in text by a number in brackets.

Participants reported on the presence of the usual physical, cognitive and emotional aspects of depression: low mood ("everything became bleak and dull") [2], feeling flat (including "emptiness") [3], poor concentration [2], low motivation (e.g. "difficult to get out of bed") [4], tiredness [3] ("complete lack of energy when in depression, which drags me down"), sleeping problems [3] ("awake at night and can't get to sleep, sometimes sleep for most of the day after") and tearfulness. Difficulties with making decisions [2], dealing with changes and being generally "overwhelmed" were also mentioned. One participant uses a vivid metaphor to describe the effects of depression on broadly understood perception: "it affects your outlook, almost like your optical lens don't distinguish the brighter colours as much as they should any more, so everything just dulls down".

Three of the participants spoke about the feelings, which could possibly be described as confusion and uncertainty of the future ("emptiness, no sense of direction", "it's a bit of a fog", "feelings of despair, don't know what to do, how to get by, how to get on", "I know what's behind me, but I don't know what's ahead, what's in front, so I'm just in here, because I don't want to go back, but I'm worried what lies ahead"). These responses possibly reveal much more about participants' depression, including the lack of self confidence and trust in own decisions, as well as existential anxieties. Among, and possibly because of, these uncertainties, it was important for at least two of the participants to remain "in balance" ("avoiding highs and lows", "trying to keep things steady", "not to swing between highs and lows, avoid artificial highs").

Two participants recognized how increased anger, directed internally (“feeling angry with myself”) or externally (“pilled so much negative energy, anger, frustration”), affected them physically (migraines, “it affected my blood pressure”) and emotionally (“rather than exploding, releasing that energy, I imploded”). Anger remained in a strong connection with depression for one participant, who reported that in her/his youth she/he had been “angry with the world, wanted to change it, but everything you may change is yourself, so you project your anger onto the world”.

Four participants spoke about the tendency to withdraw from contacts with other people when they were depressed (“shut yourself from the world”, “don’t want to talk to anybody”, “want to hide away from it all, difficult to share, want to be on my own, but this makes me feel worse”). One participant explained that it was difficult to be among friends “not being the person who they expect me to be” and she/he adds: “I don’t want to let them down and I don’t want to be pushing them away”. This effect seems to correspond with the reported feeling of guilt (“failure”, “just a lacking”) and “a fear of not being able to be the kind of person that I want to be”.

Two participants admitted that they did self-harm and sometimes had thoughts about self-harming, which they strived not to act on (“self-harm urges take a lot of energy”). One person attempted suicide several times and another felt suicidal occasionally (“suicide – sometimes I think like that, just can’t cope with things”, “at worst I’m suicidal, not finding much point in life”). Another participant mentioned the idea of committing suicide at some point in the past, but added: “this is not an option for me”.

Other features of depression mentioned by participants included: consciousness with own age and mortality (“I feel old and who knows how much time I have got left”), difficulties with verbal expression (“I find it hard to articulate things, getting non-verbal”) and a feeling of weight and effort (“life is a struggle”, “it’s like a weight, lies on your being”).

All participants located the beginning of their depression in their early teens to early adulthood. However, two participants admitted that they had become aware of their condition relatively recently, in their middle age (“depressed ever since I was a child, but came as a revelation last year”). One participant explains how she/he assumed that her/his experience was not much different from other people’s:

“You think everybody’s like that, that it’s normal, there’s always ups and downs in life, but probably your downs are deeper and your highs are not as high as in people who don’t suffer from depression.”

Another participant described that she/he experienced “periods when very low, but just got through it and accepted that this was just my personality”.

Difficult family situations, especially in early life (“things not great at home”, “difficult adoption in family”, “upbringing was not ideal”, “unbearable situation with step-father”), were identified by most participants as surrounding the beginning of depression. Bereavements and losses were also highlighted, including “a sudden loss of responsibility which I experienced as a kind of bereavement” and divorce.

Other possible triggers of depression, mentioned by participants, included alienation from peers at school and increasing pressure at work (“as I get older, things seem to “pile on”, for long time I managed to keep afloat, but struggle with it now”).

One of participants’ responses highlights the paradoxically positive consequence of falling deeper in depression, when it can no longer be ignored and forces to look out for help:

“The good thing about ending up in a crisis is a fact that you can’t recover enough to get to normal on your own, so this forces you to look for other ways, for help and to try something and not to ignore the severity of your situation, consciously or unconsciously, so looking at it like that, it can be seen as something positive.”

Another participant shared that there were periods in her/his life when she/he felt free of depression and described what that meant:

“When you’re free you’re feeling in balance. You feel you can be yourself, you come closer to realize your own potential, you become more confident person, who has had good education and can express things and pursue interests. More things become possible.”

Both responses illustrate well how depression is being reflected on by participants in this project and how they attempt to understand its mechanisms and to give it a meaning.

4.3.2.1.2 Perception of self

When asked how they would describe themselves, participants used expressions such as: “quiet”, “reserved, especially in cultures where people are more open”, “interested in people”, “anxious”, “not terribly confident”, “quite fun person with a good sense of humour”, and also: “wild”, “quite impulsive, I don’t think about things”. Other descriptions concerned being shaped by events in the past (“have not had a particularly easy life”), situations at present (“having difficulties coping with life at the moment”) or hopes for the future (“I think there’s a lot more potential there that I’ve actually realised”). One account brought a painful realisation of self being shaped by others:

“I have found certain things difficult, things that have come out recently, for example the need for validation from other people - I realized that what has been there was brought by other people.”

Participants generally acknowledged that others might see them differently, as “reliable, trustworthy”, “taking life too seriously”, “resilient, don’t give up despite the pain”, “mad, doesn’t shut up, driving crazy”, “quite confident and capable”, “stubborn”. One participant said: “people trust me but I don’t”, while another thought that other used to consider her/him a “friendly, welcoming, kind, irritating at times, a normal nice person” and added: “I suppose it’s there somewhere”.

4.3.2.1.3 Ideal self

In their initial interview participants were asked how they would like to be, with intention to identify areas of their lives and self in which the most uncomfortable difficulties were experienced. Participants’ answers helped to understand the real impact of depression and determine therapeutic aims (further described in more details, see section 4.2.4.2)

Concerns with physical health and practicalities of everyday living were expressed (“I want to be on a manageable level of depression and not to have so many physical issues because of it (migraines)”, “I need to be physically fitter for a start”, “be able to sleep again”). One person stated: “Sometimes I don’t feel like I have life anymore, I need to sort everything out and be back at what I was doing – getting job, saving money, go

travelling.” Other images of ideal self included: being more confident, being more adventurous, being able to manage anger better.

However, the issue which appeared in participants’ responses most often concerned their relationships with others and general willingness for those connections to be more meaningful and satisfying (“having relationships with people which would be more normal, more open”). In some responses the difficulties with trusting others and expressing emotions were highlighted. One person shared:

“I would like to be more comfortable in a company of other people, meet friends, be able to have relationship with other people not based on meeting once a year, but actually be involved and have somebody involved in my life too, to feel part of the family”

and another added:

“I find it hard trusting people, forming relationships. I would like to get myself to a place where I would be able to form relationships, to feel better about myself, to like myself a bit more, to be closer to other people.”

For at least four participants, speaking about their difficulties with forming and sustaining meaningful relationships caused visible emotional distress and seemed to have been touching on one of the most painful aspects of depression.

Among other significant wishes and desires was metaphorically expressed need of lightness, while depression seemed heavy, suffocating and difficult to lift:

“I’d like a little bit more lightness in my life. (...) It’s like a door that has been locked for long time, it has to be unlocked to let the air flow. That door (...) is locked tightly, it’s been an obstacle, that doesn’t allow the weight lifted.”

Finding meaning in life and being needed was also noted by one participant as essential for a satisfying life free from depression:

“I would like to be purposeful (...), to have a place and some meaning. I would like to contribute in some ways. (...) It’s probably the need to be needed at the base of it all. The way that you can have meaning in your life is by helping, by giving to other people.”

4.3.2.1.4 Coping strategies / resources

Participants revealed various coping strategies which they used in an attempt to fight depression. These resources may be grouped into: 1) active (actions, activities), 2) social (people, family), 3) mental (thinking patterns, learning experiences).

a) Activities

Among activities, which participants find helpful in dealing with depression, were: yoga, listening to music, crafts (woodworking, jewellery class), good book or tv show, dance class, breathing and relaxation exercises, outdoors, walking, hiking and cycling. Generally, participants spoke about feeling better “when out and about” and willingness to be involved “in more things” (“it’s better for me to work than be in the house, when the things on my mind make me worse”), but acknowledged that poor motivation often prevents them from further engagement. One person mentioned that involvement in voluntary work was beneficial for her/his depression and to some extent helped to resolve problems with low motivation: “I need to get up and do that, because I promised somebody else that I’ll be there” – the social aspect of the voluntary work seemed to be more motivating than other activities that do not necessarily involve commitment to others. Another person said that keeping up energy levels was crucial for an acceptable quality of life.

b) Relationships

In initial interviews participants were briefly asked about relationships and people important in their lives. Generally, social resources were either missing or lacking in quality for all participants. For some, their relationships with families were at least difficult (“I’ve become quite isolated from my family, rarely have contacts with them”, “sister, supportive, but living far”, “relationship with son leaves a lot to desire”, “never good relationship with parents”) or nonexistent (“don’t speak to my family, parents not supportive, have not seen them for many years”). Other difficult events in families were mentioned including divorce and bereavement and there was generally little trust in lasting relationships among the participants. A desire to share problems and thoughts around depression with closest family was expressed by two participants, who both felt that they would not be understood and therefore would not feel comfortable speaking

about depression to their families (“I don’t know how to, I think they would shrug it off”, “I’m not sure he [son] would be comfortable with me speaking to him about depression, I have not probably expressed it to him in so many words”). However, some participants managed to identify friends or relatives, who they felt were supportive and whom they could trust (“closest friends know about depression, accept it”):

“I feel safe in daughters’ company, it’s very different than with other people, I can laugh, I can forget myself, I just feel secure, if I’m feeling down I can say it, I can be honest with them”

One participant described her/his struggle to keep in touch with friends and her/his attempt to show appreciation for offered support, even though it is not helpful:

“They are supportive, but I find it difficult being with them not being the person who they expect me to be. People try to fix it and make things better, so I don’t want to let them down and not appreciate their kindness and support, I don’t want to be pushing them away.”

c) Patterns of thinking

It seems significant that most of the participants recognized cognitive processes to have an influence on their mood. While some participants were speaking about inability to concentrate and therefore difficulties with activities requiring directed attention, like reading, others reported that they enjoyed a good book or a television show as they could offer a distraction from unhelpful thinking, which could otherwise be “difficult to control”. Generally participants seemed to agree that such distractions were helpful and described several techniques which they used to alter their thinking: “I try to keep busy, try to avoid negative thinking”, “I immerse myself in things that do catch my interest”, “I try to block it, try not to think if I can, because it’s all jumbled”. One participant added: “If I’m thinking about something else instead of thinking about me, that helps.” While all methods may offer some relief from unwanted thoughts, they mostly focus on simply repressing them, rather than altering thinking patterns.

Two participants shared that they avoided planning and expectations as a method to maintain a helpful balance and avoid disappointment:

“I live on a day to day basis, with very light future planning. Not having expectations, taking life as it comes, keeps you safe from bad deceptions and disillusion (avoiding emotional rollercoaster) - don’t dwell on it, as it makes it even worse.”

4.3.2.1.5 Previous experience of therapy

There has been some experience among the group members with using professional support and education to tackle cognitive and emotional difficulties by learning coping strategies. One person took part in a self-harm support group while another attended a stress control course, recommended by the GP.

Before taking part in the project, all participants used to have some experience of therapies or professional support of different kinds. However, their level of engagement in those experiences and their evaluation differed quite significantly. Generally, participants spoke of their difficulties with asking for help (“I don’t really expect help from other people”) and admitted that they often either waited for improvement for long before deciding to seek support or were offered support by a professional at a point when they were in a deep crisis. One participant said that joining a peer support group was “the only proactive thing I’ve done, previously it was just keeping busy, I haven’t sought therapy before”. Another participant elaborated on her/his first time realisation that she/he suffered from depression: “What do you do? You commit suicide? That’s not an option for me. You seek professional help, or you try to work your way up the ditch yourself.” All participants in this project had tried to help themselves in some ways before engaging in any type of treatment, usually at a point when it became clear that professional support is needed.

Three of the participants were taking antidepressant medication at the point of start of their art therapy. One member of the group described her/his experience of medication as “not worse, not better”, highlighting the effect of flattened mood: “I just feel flat, like I’m in neutral”. Another participant, on medication for many years, seemed to have fully accepted its presence in her/his life and could not imagine life without antidepressants, although their effect was satisfactory only to some extent, not allowing her/him to experience full engagement in life, as she/he reported.

All participants seemed to have informed their GPs about their depression at some point. For some, their GPs were the first professionals to mention about depression and suggest further investigation. Others were either aware of depression for long or it was identified by other health professionals (e.g. in emergency services). One of the participants was seeing a support worker once a week during the course of art therapy and used to see a community psychiatric nurse due to her/his overdosing in the past. She/he reported the experience of community mental health team to have been unsatisfactory and discouraging, but valued her/his time with the support worker. Two group members have used an opportunity to be a part of a self-help group in the past. These groups were not intended as psychotherapies and included a self-harm support group and a peer support group for adults experiencing hoarding difficulties.

All participants in this study have had some experience of talking therapies, with cognitive behavioural therapy (CBT) being the most often recognized and tried approach. Two participants were referred to CBT sessions in the past and one participant has finished her/his brief course of CBT sessions just before the start of this project. One participant admitted that she/he had not finished her/his course of CBT sessions, as she/he found the experience difficult and increasing her stress levels: “I hated that, hated sitting in a room and talking about things. It was stressing me out, just making things worse.” Another participant shared that she/he was “not too sure about CBT”, as she/he found the principles comprehensible while in the sessions, but difficult to adopt in life outside of therapy room: “(It) all makes perfect sense at a time, but I just can’t put it into practice.” Cognitive analytic therapy (CAT) was tried by one participant and at least two participants tried counseling, which in one case seemed to have helped with gaining insight, but did not offer solutions: “I have analysed myself, but didn’t manage to get healed”.

Only one participant had been seen by a psychiatrist on a not frequent but regular basis before and during the project and one other member of the group had been referred to a psychiatrist by her/his GP just before the art therapy sessions. She/he found the GP’s suggestion to be difficult to accept, considering the need to see a psychiatrist to be the last resort, reserved for people severely impaired by a mental illness (“it intimidates me”).

None of the participants has had an experience of arts therapies before the project. Two participants admitted to have read some info about art therapy online before deciding to take part in the study. Most participants reported that they have not been engaged in arts activities since school, but they used to enjoy art making in their early years. At least three of the participants shared that they were keen audience and appreciated art or its history or just “enjoyed looking at it”. Most participants referred to visual arts but one person highlighted her/his interest in other forms of art including creative writing and drama in which she/he engaged at some points of life. Two group members spoke of being aware of their creativity but also mentioned about the difficulties with actually creating something tangible: “I can make things, I can design things, but depicting them in drawing is difficult”, “Creativity is still an undeveloped side of me”.

Generally, there have been a number of experiences of different treatment options within the group, with some of them valued more than others, but none identified as particularly helpful. All group members had been given or created opportunities to engage in common treatments like medication and CBT, but have not had a chance to experience other talking or arts therapies, particularly based on psychodynamic or humanistic principles. While they may belong to a group of clients particularly challenging to treat, they may have not by far been offered a treatment suited to their needs and therefore hoped that art therapy might be a better solution.

4.3.2.1.6 Expectations and feelings about starting art therapy

Before the start of the project the participants shared their feelings and expectations of their treatment. Uncertainty seemed to be above other feelings in responses of all participants, who seemed to wonder whether the therapy might be effective (“I don’t know if it will help or not, I’ll see what happens”, “I don’t know a lot about it, but CBT didn’t help me, so I’m not sure whether I have hopes”, “no expectations”). There seemed to have been a general feeling that art therapy could facilitate and aid recovery process (“just that it would made me feel a bit better”, “I want to try and help myself to recover”). It is interesting to note a passive and an active approach in the examples above.

Usually further inquiry into participants' expectations revealed more personal aims, which helped in shaping exact treatment interventions (see Figure 23). One participant acknowledged that she/he expected the therapy to be a "hard work which only I could do". Another person similarly acknowledged that the therapy is likely to present challenges:

"I have a few attitudes to overcome. I'm success orientated, I'm a bit of a perfectionist when it comes to art work. I would want to create something good; I would need to fight against that - a challenge in itself."

The same person recognised that the therapy could offer a setting where it may be possible to deal with personal attitudes ("I do understand the benefits of participation, getting immersed in something and relaxation which may come from it"). Another participant mentioned that because she/he used to enjoy working with arts materials, "it may be a rediscovery". Gaining insight into and opportunity for expression of emotions was also expected ("hopefully getting more insight into my feelings - finding it difficult to explain feelings, maybe an outlet for emotions"). One participant mentioned that she/he hoped for "not talking but doing" during the sessions ("which suits me as I'm a hands-on person"). It was also hoped that the therapy would offer a learning experience and a relief from self expectations ("I'm hoping to learn from it and be free from expectations I put on myself"). In addition to the mentioned expectations, art therapy was considered by one participant as something special in every day routine ("I have classified it as frivolous activity, one on those I don't have time for. I see it as a luxury").



Figure 23: Participants' expectations of art therapy (initial interview).

All participants recognised that art therapy might present challenges and spoke of a degree of anxiety brought by engaging in a new experience. The origins of this anxiety could be traced to two most often highlighted areas: a fear of connecting with painful memories or knowledge about oneself (“a bit nervous of going back in time and experience, confidence drops when I think about it”, “scary that it would bring out difficult stuff about myself”) and a fear of being in a group and expectation to interact (“anxious about interacting with strangers in the group”). One participant recognized the expected advantage of overcoming the fear:

“I’m not a group person, I’m quite solitary person, so there’s a bit anxiety of being in a group, but I can manage it, it’s a part of learning to form relationships with other people.”

Another participant admitted to anxiety “of a group setting and hospital setting”. Among the reports of nervousness and anxiety were the accounts of being “positive” and “open” and that the members of the group felt inquisitive towards the experience (“but I would like to do it”).

4.3.2.2 Themes from final interviews: immediate evaluation of the experience and outcomes of art therapy

Final interviews, similarly to the initial, had dual purpose: 1) to assess participants’ psychological state immediately after the finished therapy and ensure their safety; 2) to evaluate therapy. The second aim also included two separate aspects, corresponding to the aims of this research as a whole: providing more insight into direct outcomes of therapy or any changes following the treatment and evaluation of the intervention and the research process. Clinical and research aspects could not easily be separated here. The findings will initially revisit participants’ expectations of therapy, define the experience and identify significant moments, which will be followed by analysis of outcomes and evaluation of the therapy. (Some aspects of evaluation will more appropriately be presented in section 4.4.6, where assessment of the intervention is attempted). Finally, most significant themes coming from the interviews will be revealed to offer deepened understanding of participant experience.

4.3.2.2.1 *Expectations and reality of therapy*

When prompted to verbalise how the reality of therapy met with their expectations, most participants shared that the experience was not what they expected it to be. Interestingly, in initial interview most participants said that they did not have specific expectations, but final interviews revealed that certain ideas which group members had had about therapy were not confirmed by the actual process. Confusion with whether there were expectations present in the group and how prominent they were is best illustrated in one participant's comment: "I didn't know what to expect but it wasn't what I would have expected." Another participant admitted: "I think that I had quite high hopes and expectations for it."

The reality of therapy appeared to have been quite surprising for the group members. It was expected that the therapy would be "more lively" ("but then I figured out that [therapist's name] doesn't want to push the group in one direction") and "more structured" ("so that each week we were told that the theme is x"). Two of the participants shared that they expected the therapy to "be exploring thoughts, feelings" ("and help me move forward in some way") and to be "a way of getting things out on paper" and admitted that they did not feel that these expectations were confirmed ("I didn't feel that we really did that").

The general impression coming from the interviews was that the participants' expectations were in fact much higher and complex than they were able to admit before the therapy and that most participants were left with a feeling that art therapy was much different from what they expected. There may be several interpretations of the fact observed. Firstly, little public awareness of what art therapy involves could have led to the participants' varied and/or unrealistic expectations. Also, it is possible that actual participation in the project offered more understanding of the therapy and increased expectations by revealing new possibilities.

Interestingly, objective matching of initially declared expectations with participants' responses elsewhere seems to indicate much more consistency in that the therapy appeared to have been (as expected): challenging, bringing insight, a hard work, a learning experience and rediscovery (more on these concepts in further sections). It seems therefore apparent that, while the therapy confirmed many of declared

expectations, the predominant subjective feeling among participants was that it had been different and surprising.

4.3.2.2.2 Experience of therapy

While from a therapeutic perspective art therapy was not supposed to bring pure enjoyment and therefore there were no expectations that participants would 'like' the process, it was expected that certain aspects of the therapy would be 'liked' and others 'disliked'. All participants shared that overall they were glad to have taken part in the therapy and some added that they found the experience 'valuable' and 'interesting'. It was also very often described as 'challenging' (which will be discussed further in this section). One person shared how therapy induced simultaneous feelings of achievement and relief: "I suppose a small achievement may be in that I put myself into this, I've done it, I started the whole thing. But now I feel a relief that it's finished." It seems important to notice that the feeling of accomplishment was induced by the fact that participants not only needed to make decision about joining the group, but also needed to clearly indicate it to the researcher and make the first contact. Autonomous motivation (Zuroff et al. 2007) seems to enhance satisfaction from participating in therapy.

Generally participants agreed that among the enjoyable aspects of therapy were the art making itself and "meeting other people and looking at what they produced, what approaches they took". Engaging in creative process and sharing the experience with others seemed the valued aspects of therapy. However, the latter carried a more complex emotion and was also the source of participants' distress, which will be looked at further in more detail.

The dislikes, that participants listed, included: "the slow pace", "uncertainty of what was acceptable", "talking", sitting in a circle and discussing artwork and "long silences". Some of these will be later discussed (see section 4.4.6) as part of the evaluation of the intervention. At this point it is worth noting that negative aspects of therapy may stem from at least two background: 1) the faults in the design or facilitation of the intervention and 2) the aspects of therapy which were most challenging for the participants and therefore caused a degree of distress and were least 'liked'. The first source of negative experiences will be further looked at in section 4.4.6, concerning the

intervention itself, and another will be further explored later in this section, where the theme of ‘challenges’ is identified as one of the most prominent in this phase of the study. While it’s not always possible to distinguish between those two very different sources of participants’ distress, the first may be eliminated from future studies with improvement of the intervention and its delivery, and the other should be sympathetically acknowledged by therapists as indication of the areas in which the therapeutic process may bring most benefits but may also present most challenges to both the group members and the facilitator(s).

4.3.2.2.3 Significant moments

Participants were prompted to share particularly memorable moments from their therapy in aim to identify the most significant aspects, the meaning of therapy for them. While answers were very different, they all included intense feelings, highlighting the most profound experiences. It was clear that for every participant there had been particular moments in their therapy which affected them emotionally for various reasons. Participants used expressive vocabulary while talking about those experiences: “that surprised me”, “that was meaningful”, “this struck me”, “it was strange”.

Two of the responses identified a rediscovered aspect of self (ability to express oneself and ability to connect with specific themes). Another three responses concerned moments when the group seemed to have made progress in therapy. All of these accounts were based on impressions from the discussion at the end of sessions. Other participants’ effort and active engagement in the discussion is another common feature in those best remembered experiences. It seems apparent that most memorable moments in therapy concerned either a particular personal insight or an increased connection or meaningful exchange between the group members. Figure 24 includes direct transcript of participants’ responses, as they seem too important not to cite in original format.

1	“What surprised me was that I managed to get something on paper each time, naturalness with which this came about, the feeling that whatever I reproduced was a genuine form of expressing myself.”
2	“When X said that everybody used black on that day, it was strange to find out that everybody chose the same colour. No one was paying attention to what others are doing and this was the dominant colour in everybody’s work.”
3	“When we were given a theme and the theme was ‘confidence’ – I thought ‘ok, that’s something I can connect and work with’ and I thought I got more out of it.”
4	“Maybe it was the first time when there was a degree of conversation at the end. This for me was a big step forward, there was a slight change, people maybe felt more comfortable. There was this change from one session to another, this has been quite apparent.”
5	“Last session, me trying open up the memories. That was meaningful because it created a different atmosphere in the group somehow. Sometimes I got impression that we had touched on something a little bit difficult, upsetting, then it immediately stopped. I remember this with X, with the painting X did on one occasion – everybody felt for X, that X was struggling with something. There were enjoyable moments when people were talking about their work. I felt that Y was trying to push up ideas for us to talk about and I wanted to respond but I looked at others and I thought – ‘better not’. Y was trying to be slightly challenging about [her/his] work and sometimes about other people’s work. This is along the lines of what I was expecting from the group. This struck me.”

Figure 24: Significant moments in therapy in responses of five participants (final interview).

4.3.2.2.4 *Feelings after therapy sessions*

Asked about the feelings they experienced immediately after individual therapy sessions, participants shared a wide variety of emotions, ranging from contentment and calmness to frustration and confusion.

One person noticed that art making “takes your mind off, things that maybe worried you, keeps you busy, to take your time out, rather positive”. Another participant similarly shared that engaging in art making helped her/him relax: “Feeling more relaxed. Just doing art work, you’re chilling out and you’re not thinking about anything else when you’re doing that, you’re getting on with what you’re doing.”

Some participants acknowledged that the immediate feelings after the sessions varied, depending on the point in therapy and content of a particular session. For one person positive emotions accompanying first sessions changed into more negative feelings as

the therapy progressed and became increasingly challenging:

“It varied. I left the first session feeling quite positive because it’s gone well, I liked that we introduced ourselves and that it was quite good, I liked that we weren’t given a theme and it was about getting used to paints. When I left I thought this wasn’t as scary as I thought this might be. But after several sessions I remember leaving feeling really quite frustrated, because I didn’t feel that I was getting much of the therapy part of it.”

Another participant described a reversed experience, while her/his initial relief that the sessions were over developed into a more comfortable feeling:

“At the beginning it was relief that it was over but as time progressed that lessened and although I couldn’t say that I ever looked forward to it, and I’m not even sure whether I could say that I ever really enjoyed that, that feeling lessened and I just felt more comfortable with the whole thing.”

Often a variety of emotions was felt simultaneously and one participant’s description of her/his feelings following a particular session illustrates well this complexity of feelings and helps understand their origins:

“I did think about it afterwards, trying to understand what was said and the [art]work and I could remember it all very vividly, and also my own difficulties. On one particular occasion, I can remember the feelings were so intense. I felt very jangled after that one. I thought I can’t even put some colour on the paper. I felt a bit uncomfortable, annoyed with myself, a bit low, though ‘oh, dear, this was supposed to be fun’. I thought about the people. A bit of confusion about the purpose of it, so I was trying to analyse things a bit too much perhaps. A real mixture of feelings. I felt quite jangled, quite low [as] if I had really struggled with something. Then I would think ‘I must get the idea for something ready for the next time’. But my mood would lift again.”

A range of emotions induced by the events in therapy sessions seems to highlight the complexity of therapeutic process and possibly offers more understanding of the struggles participants’ experienced in the course of their treatment.

4.3.2.2.5 Outcomes of the therapy

While the final interviews took place immediately after the therapy had finished (on the next day after the last therapy session), the following responses capture participants' evaluation of their treatment when the experience was still very fresh and accessible in the memory. In the light of what participants shared in their follow-up interviews, it is important to note that at this point in time perceptions of the therapy were more likely driven by recent emotion as there was not time for the participants to think through and consciously evaluate their involvement in the project. This seems an important contrast to the content of follow-up interviews, which will be discussed later (section 4.3.2.3).

Generally, immediately after their therapy most participants' feelings about the outcomes of their treatment included a degree of confusion and quite a vague impression that it has brought some results, often difficult to name at this point in time.

All participants admitted that the experience was difficult and it seemed that extensive challenges coming from involvement in therapy (discussed further in this section) made it difficult to assess whether and how art therapy had been helpful. One participant shared that the therapy "highlighted a few things on a personal level" and another said that "it was really interesting experience, it made you think". One person highlighted the importance of the length of therapy ("If you take it over longer period of time, you would probably see more results."), which will be discussed in more detail in section 4.4.6.1. Another participant shared that while she/he enjoyed "the actual art making", she/he didn't notice the benefits of therapy ("on a deeper level I don't think I got much of it"). For a yet another account, one person said that she/he "didn't find that therapeutic for me. (...) I didn't feel I progressed." Interestingly, the same person later in the same interview shared: "I did get things out of it. I could explore my own responses, physical and mental, so this has been valuable."

It also seems apparent that most participants reported doubts about the purpose of their therapy and regarding whether and how it could be helpful for them. These 'doubts' will appear later in the assessment of feasibility (section 4.4.5). It seems possible that the confusion around the benefits of therapy was caused by either participants' low self confidence and expectations about themselves ("I didn't feel I progressed") or by their recognition of therapy as a not necessarily pleasurable

experience and not one that brings instant relief or other easily identified result (“I’m not sure in what way, but this has been important.”). Especially in one response the confusion, heightened expectations of oneself and little self belief is apparent and seems appropriate illustration of the feelings most likely shared by at least some members of the group:

“Towards the end I felt comfortable and had something to hold onto and I felt I was making some kind of progress - that that confidence was building. But I didn’t feel that process taking place really. Personally I felt I was back at the starting point each time.”

Another quote again highlights the vague intuition of the therapy’s meaning: “I don’t know what influence this would have on anything but this has had its influence, it pushes you a bit.”

Despite common difficulty with evaluation of the therapy process, the participants indicated some areas in which they felt changes took place as a result of therapeutic process. Those changes are listed and complemented by direct quotes from group members in the Figure 25.

<p>1. Increased awareness of others</p>	<p>“Hopefully overall, it would just help make you a better understanding person of other people, non-judgemental, because you don’t know what is going in their own lives.”</p> <p>“I think it has given me a degree of insight into other people with perhaps a similar problem. You know that half the world has depression but it’s still very isolating.”</p> <p>“It’s given me an awareness of other people, having their different problems, but maybe with the same kind of results. This has been quite important.”</p> <p>“It was interesting to view people who have their own issues to deal with and in that sense it makes you aware that there were other people that were doing their best.”</p> <p>“The impression I had from other participants was that they probably got less well with their depression than I was.”</p> <p>“Meeting other people and looking at what they produced and different approaches that they took -I found that all quite fascinating.”</p> <p>“Eventually, I just saw beautiful people who were stuck in themselves.”</p> <p>“An important thing is the people.”</p>
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<p>2. Increased self awareness/knowledge of self/realization of own needs</p>	<p>“I had discovered that I need to be connected in some way and that’s something that I learned. Another thing that I learned is the actual process that takes place, the stressful reaction that I get. I could explore my own responses, physical and mental, so this has been valuable too.”</p> <p>“If you can stop directing everything, if you’re allowing it to flow and let it grow, perhaps that’s part of what’s suppose to happen. Maybe that’s how you benefit from it, by enabling that process to take place?”</p> <p>“Thought: I am stronger than I think.”</p> <p>“I found it difficult to share. I felt that they [other group members] found it a lot easier and I found it difficult.”</p> <p>“Towards the end I felt comfortable and had something to hold onto and I felt I was making some kind of progress, that that confidence was building. But I didn’t feel that process taking place really. Personally I felt I was back at the starting point each time.”</p>
<p>3. Further exploration of creativity</p>	<p>“I joined a choir recently. (...) Singing is good for the mind and the body. It’s something which doesn’t come up naturally for me so it’s taking me out of my comfort zone which is sometimes good for me.”</p> <p>“I’m looking at getting into furniture design. I’ve been also looking at strain instruments making course.”</p>
<p>4. Sense of achievement</p>	<p>“And there is, I suppose, a small sense of achievement that, difficult and uncomfortable though this was at times, you keep going. There is a wee sense of achievement there.”</p> <p>“I suppose a small achievement may be in that I put myself into this, I’ve done it, I started the whole thing.”</p>
<p>5. Friendship within the group</p>	<p>“I think people wanted to get to know each other and several of us made attempts to do that, with a little success but not a lot. I’ve met X (...), so that’s a wonderful thing for me.”</p> <p>“I think that on a personal level the breakthrough was that I became friendly with X. We walked home one day together, had lovely chat and that made the next time when I came in almost as if I had a friend there.”</p> <p>“Next time X and I walked together along the street (...), it’s almost as seeing another part of people. That made me feel good because I felt another connection which maybe hadn’t been there before.”</p>
<p>6. Increase of anxiety</p>	<p>“I found it made me anxious, seemed to trigger all my anxieties, it probably did not have that effect on everybody. (...) I’ve noticed other people seemed to relax more than I did.”</p>
<p>7. Physical implications</p>	<p>“Pains are a lot less, less migraines, my sleeping is still not quite up to scratch but it’s not too bad.”</p> <p>“I’m not using my sleeping tablets a lot now.”</p>
<p>8. No changes</p>	<p>“It’s very similar. I don’t think it has had an effect of my mood.”</p>

Figure 25: Outcomes of art therapy as reported by the participants.

It seems significant that an increased awareness of self and others was most often noticed outcome. Participants shared a growing appreciation of others and their problems and an increasing realisation of important aspects of self. A feeling of achievement was also present and willingness to explore own creativity further was expressed. Friendship which formed within a group was a much valued outcome by participants involved. An increase of anxiety was also mentioned and improvement in sleep patterns was noticed.

4.3.2.2.6 Themes significant to participants

While during the final interviews the participants were on occasions prompted to answer more specific questions (e.g. concerning their expectations of therapy or areas which they liked and did not like), much of the conversation aimed to follow what they wanted to share in connection to their roles as participants in this project and as members in group art therapy sessions. Analysis of these open responses revealed themes, which presented themselves (and therefore seemed particularly significant) in all or most of the interviews. Certain topics seemed to be of an interest to all participants and brought up by them without prompts from the researcher. They were grouped into meaningful themes, which will now be presented.

a) Being in a group

It seems that being a part of the group was both an attraction and a challenge for most and possibly for all participants. One person says: “It didn’t comfort me to be with other people, but it wasn’t the opposite. It didn’t make me feel bad about it, but it wasn’t exactly a comfort.” Another participant admits that she/he found it difficult to be in a group (“possibly more difficult that I thought it would be”) and adds: “I found it difficult to share. (...) Because it’s people you don’t know as well, it’s easier to share with people you know.” Similarly, another person mentions that “it felt quite awkward to be with people, share images with them”. Other participants, despite admitting to anxiety in connection with being in a group in their initial interviews, shared that the experience was “not too intimidating” and in fact “not as bad as I thought it might have been”.

Being in a group seemed especially important in designing of the project focusing on depression. One person notes that the nature of depression itself enhances the tendency to isolate even in the presence of others: “Because of the nature of depression you are very isolated from other people, that’s what happened in a group.” There is an ambivalence between the need to be connected and the anxiety which often prevents meaningful communication. This paradox of strong need met with even stronger fear often leads to avoidance and frustration – feelings present in most responses.

Some of the participants shared how they wanted the group to respond and connect with them. However, the same participants admitted that they themselves found it difficult to open up. It seems that the process often lead the group in a stuck place, where individuals’ desire to connect remained most often unexpressed and therefore could not receive a much awaited response.

One person reports on her/his observation of cautiousness and consideration for feelings of others among group members: “There was no actual dialogue (...) and I think that in a group set up we were all being very cautious because we all realised it’s our own personal space.” There seems to be an impression that too much consideration for others on occasions disturbed communication. Another participant has also been searching for signs of connectedness: “And there wasn’t even very much eye contact and that made me feel nervous.” Later she/he adds: “I was understanding why this was not happening so much, it did ease up as time went on”. The same person seemed to have hoped for more interaction initiated by others and she/he notes: “I don’t think I anticipated the effect that other people’s problems, whatever they were, would have on their involvement in the class.” Another participant explains what sometimes prevented her/him from connecting in the session: “Sometimes you feel like under pressure when you’re in the group and it’s easier sometimes to talk when we’re leaving.”

While most or all participants felt that they would have liked more connectedness in the group, they themselves often found it difficult to facilitate communication. (“Had there been an atmosphere of people being comfortable talking about inner personal feelings, I would have felt able to open up a bit as well.”) One person explained how she/he attempted to connect meaningfully with the group on the last session:

“I was trying to talk about personal memories (...), because I felt otherwise I can’t let people know who I am. I’m not expressing it in an artwork or any other way because I’m so frozen. That was my way to let people know who I was. I wanted to see what would happen and it seemed to be a genuine conversation then in the group.”

From therapeutic perspective the situation seems to illustrate readiness for more responsiveness in the group. The fact that communication was attempted in the last session seems to highlight the anxiety associated with meaningful connectedness and that opening up was considered a risk.

b) Challenges

Experiencing therapy as a challenge seemed to have been a theme common for all participants and actually anticipated (“I did find it quite challenging and I think that I predicted that I would”). Some participants mentioned that engaging in therapy process required a degree of effort from them (“As time went on, things did kind of ease up a little bit, but it took effort for me to try and make it so”). One person admits that while art making was acceptable, discussing the process in the group proved more difficult (“I found it hard talking”).

While difficulties were experienced by all members of the group to some extent, they had more than one source and two areas seemed especially challenging: working in a group setting and self expression. These will now be presented in more detail.

Being required to work in the presence of others and expected to share and discuss seemed to cause difficulties to all participants. Many challenges were experienced “because of the group”. Even the initial introductions were identified as difficult: “The very first time when we came in, when I see a circle of chairs my heart sinks. It’s the going round, giving your name, talking about yourself, it’s really hard to do that.” Later, the sole task of making artwork in a group often felt uncomfortable: “Actually working in front of other people, I felt very self conscious doing that.” Group discussions towards the end of sessions proved even more challenging. One participant admits: “I didn’t like the bit when we all sat in circle and looked at and discussed our paintings, I found that really quite painfully awkward.” Another person shares:

“The end discussions I found difficult because I didn’t really want to say anything that would hurt, offend or make anybody upset. (...) The silences were very difficult for me to cope with, trying to fill it with something, anything.”

The same was considered challenging by another participant: “I felt very, very uncomfortable with the long silences.” It needs to be highlighted that not all participants experienced being in group as a significant challenge, but some admitted that they would have felt more comfortable in an individual therapy:

“On one to one I wouldn’t have had the problem and a dialogue would have been possible, which I would have found comforting, I would have had something to hold on to. It was that not having something to hold on to that I found problematic.”

There may be of course many reasons why some participants would prefer individual therapy mode. It seems possible that, while a need of connectedness may not have been fulfilled in a group situation, a more personal contact with therapist promises more reassurance.

Besides challenges of being in a group, most participants shared their struggles with the process of self expression (“I found it quite difficult, personally being able to express things”). Many responses evoked a sense of feeling “stuck” or unable to engage in the creative process spontaneously. One participant shares: “A big difficulty was thinking what to do and trying to translate either thoughts or feelings onto the paper. I found that so hard.” Similar notion appears in another person’s response:

“Not only doing things but thinking of what you had to do I found very difficult. Because there was a relatively short space of time to think about it and do it, there was a pressure there to think of something.”

One person seemed to especially struggle with spontaneous expression. She/he explains how planning beforehand helped to cope with the challenge of being left with a blank page: “If I planned, if I could anticipate what I was going to do, I was able to modify it a bit, but if I had nothing pre-planned, I couldn’t cope.” The same participant describes her/his reaction at the start of art making:

“My mind just went blank. It’s a stress reaction. My anxiety just hit me. That was my biggest problem. And then the materials did not match what my idea was so then I had a conflict. There was a lot going on.”

c) Depression - as elephant

While the group was created and facilitated with addressing depression in mind, the participants often felt that depression remained “an elephant in a room” and was not directly addressed:

“It was kind of like an elephant in the room (the reason why we were there), that you couldn’t speak about, but it was there. That was the door that should have remained closed.”

This effect was noticed by most participants and their responses seem to suggest a desire for the theme of depression to be more directly present in the process of therapy despite the distress which this would inevitably cause. There seems to have been a readiness present among group members to be exposed to most challenging issues but at the same time there was an understanding and almost anticipation that this may be too disturbing for other participants. (“I didn’t really want to say anything that would hurt, offend or make anybody upset, constantly trying to find something positive to say.”) One person shares: “I felt that X was trying to push up ideas for us to talk about and I wanted to respond but I looked at other people and thought - better not.” She/he also adds: “I didn’t feel comfortable with bringing up anything contentious, challenging in any way.”

The wish for the theme of depression to appear more openly was met with anxiety, either present or anticipated (“feelings relating to depression as such didn’t really surface very often, people were scared to mention it”), which eventually led to avoidance: “Sometimes I got impression that when we had touched on something a little bit difficult, upsetting for one or two of the group members, it immediately stopped.” It seems apparent that the group members, although willing to explore more challenging themes, were unable to open up or initiate a more personal communication in fear that they would upset others. Some participants shared that they expected the

therapist to particularly support them in exploring themes around depression, as illustrated in this response:

“When an idea did come up that could be explored by everybody that wasn’t threatening, I felt, I wish that the therapist would have taken that a little bit further, and people would have felt comfortable then coming in.”

Participants’ expectation of more directiveness and structure in the sessions will be further explored in section 4.4.6.5, where the intervention is evaluated. One participant, asked whether she/he would like more depression-related themes to be suggested by therapist, shared:

“It’s kind of bizarre, because on one hand I would be willing to take it on board and do the artwork but if it was something more personal, like depression stuff, I wouldn’t feel comfortable having people looking at it and interpreting it. If it was more personal thing, I would have done my best to put it on paper, but that [sharing with others] would just feel a little bit too intrusive.”

There seems to be a paradox in the complexity of participants’ relationship with their depression and willingness to explore it further combined with apprehensiveness towards sharing the experience with others.

d) Meaning of therapy

It is apparent that while they recognised the challenging aspects of therapy and their own doubts in its effects, most of the participants acknowledged that the process was meaningful and shared their observations unprompted. It seems that certain aspects of the treatment (perhaps its openness or a degree of uncertainty) encouraged the group members to reflect on the purpose of the process and triggered insights beyond personal experience.

On a more general level, one participant shared that she/he could “see the point in doing that [drawing/painting] and talking about things” and another person admitted that the therapy “highlighted a few things on a personal level.”

The participants reflected more deeply on the meaning of self expression and sharing in a group. One person noticed a degree of impairment of creativeness in depression and wondered how art therapy could instil the readiness for spontaneous self expression: “Because in a non-depressed state you would be more creative, so how can art therapy lead you towards that state rather than require it at the outset?” She/he added that starting an art therapy felt like being “thrown into the pool and expected to swim when you can’t.” Another participant also reflected on how creativity and spontaneity may be encouraged in art therapy sessions:

“If you can stop directing everything, if you’re allowing it to flow and let it grow, perhaps that’s part of what’s suppose to happen. Maybe that’s how you benefit from it, by enabling that process to take place.”

One person recognised her/his feelings of uncertainty while creating and wondered whether they may indicate a natural progress in therapy:

“I’m not sure whether the things that I drew were a true reflection of how I’m feeling. Maybe they are, I don’t know, but I don’t feel as though they are. (...) Maybe that’s all part of the whole process.”

Another participant shared her/his struggle with uncomfortable feelings in the process of therapy and an emerging understanding of the meaning of therapy:

“It does push you out of your comfort zone because sometimes feelings aren’t comfortable. I certainly shy away from that and go “distract distract distract”. So even though I felt really “ough” at times, I had to just feel that because there wasn’t anything else to do. (...) This has had its influence.”

Being in a group had certainly influenced most and possibly all of the participants and triggered reflections on whether and how this could be therapeutic in itself. One person explained her/his understanding of the sense of working in a group:

“I can see benefits of it rather than just doing talking therapy, it’s a way to get things out. It’s probably easier to get in on paper and then speak about it. And I suppose when you’re left with other people once you’ve done something, they see it differently, you haven’t thought about it like that.”

At least three participants shared how art therapy instilled their interest in other people and appreciation of their feelings and life stories. One person noticed: “It’s given me an awareness of other people, having their different problems, but maybe with the same kind of results. This has been quite important.” Similar idea could be found in a response of another participant, who also recognised the meaning of being in a group for people suffering from depression specifically: “It has given me a degree of insight into other people with perhaps a similar problem. You know that half the world has depression but it’s still very isolating.” A wish was expressed by one participant that art therapy “hopefully overall, would just help make you a better understanding person of other people, non-judgemental.”

One person also noted the potential ability of art therapy to enhance creativity and motivation, especially relevant in the context of depression:

“I don’t know if art therapy is frequently used for people with depression, but what I certainly know from my own experience with depression is that creativity is one of the first things that goes and motivation and all that energy that you need to trigger ideas and to relax into it.”

Finally, a thought expressed by one participant seems to well conclude the perceived meaning of therapy and indicate a sense of empowerment that it created: “The therapist is also in you and in what you’re creating.”

4.3.2.3 Themes from follow-up interviews: revisiting the experience of art therapy

The follow-up interviews served dual purpose of clinical assessment and additional collection of research data. With consideration for participants and their time, they were intentionally shorter, less structured and were not recorded which meant that as thorough analysis as in case of previous interviews could not be offered. The follow-up meetings aimed to establish whether there had been any new insights that participants would like to share. One participant could not attend the interview but responded to the researcher through email and completed the required questionnaires.

In some cases the time between the final and follow-up interviews seemed to be crucial for the feelings and insights regarding art therapy to consolidate. The immediate

experience of therapy could be verified and, in some cases, enriched and deepened with time. The important research insight seems therefore to be that on some occasions the therapy process requires time for outcomes and reflections to fully emerge. While this is not a place for a more detailed clinical analysis, the follow-up interviews seemed to confirm the complexity of art therapy process and its influence on participants well after the treatment had finished.

In general, in the follow-up interviews the participants reported that they had been feeling either better or similar to when they started their therapy. One person admitted that she/he was feeling worse soon after the treatment and had recovered by the time of the follow-up meeting, but stated that she/he couldn't see the connection between the psychological state and the therapy itself. One person stated that she/he felt "similar but slightly stronger" and another added that she/he had less problems with sleep and had engaged in further voluntary and creative activity following art therapy.

One participant shared that memories from art therapy sessions were very vivid and positive. She/he confirmed that the experience was very different and much preferred to the previous attempts of CBT, as she/he did not feel pressured to talk. What one participant found especially important to share in the follow-up interview was that she/he kept the images safe but had never looked at them, as could still remember all her/his artwork clearly and understood why she/he created certain images. This understanding came with time.

Another participant shared that the most profound change between the time preceding therapy and the follow-up was that she/he now accepted the depression and recognition that she/he needed support in going through the difficult time, while previously this was unacceptable. She/he also acknowledged that art therapy would have probably been more beneficial if it happened following this realisation and acceptance of depression as well as a certain negative event, which was anticipated while in therapy and caused too many worrying thoughts to be able to "let go" and immerse in therapy.

One participant shared that art therapy brought a realisation of the origins of her/his depression in some traumatic events from the past and that it "brought new insights into feelings" and her/himself. Another person clarified the nature of the new insights,

by saying that she/he realised that an individual mode of therapy would possibly be more beneficial to her/him, as she noticed how she/he tended to control and take care of the group members rather than carrying about her/his own needs and feelings. The same person came to realisation that she/he “needed to see her/his thoughts and ideas reflected” by the therapist in particular.

What seems especially apparent is that the mentioned insights became available to the participants well after the therapy finished. One person concluded that “the implications of therapy might be very subtle” and that she/he did not detect them immediately after the treatment, as “it takes time”. She/he also explained that the implications were not specific improvements in mood or behaviour, but rather new meanings and realisations, “new insights”. The subtlety of such outcomes seems to require time to become internalised. For at least three participants the time between the end of therapy and follow-up seemed to help clarify the purpose of their treatment and notice its meaning not necessarily available immediately after the therapy when this multidimensional experience is too fresh and possibly distorted by strong emotions.

4.3.2.4 Summary: Themes from initial, final and follow-up interviews

Interviews with participants at three points in time were crucial for understanding of their experience of art therapy and involvement in the project. While participants’ evaluation of the research will be presented later (see section 4.4.6), their comments on the process of therapy were analysed and presented above and will now be summarised as a reminder and a more condensed essence of participants’ experience.

a) Initial interviews

Initial interviews enabled understanding of the characteristics of participants as individuals and as a group of adults sharing similar mental health difficulties. Participants described the nature of their depression as characterised by: low mood; poor concentration; lack of motivation; withdrawal from social contacts; tiredness; problems with sleep; increased anger; suicidal or self-harm thoughts and feelings of guilt, emptiness, weight, effort and feeling old. It is important to note that not all of the symptoms were mentioned by every participant, but some were present in most

responses. All participants located the beginning of their depression in their teenage or early adult years. However, some mentioned that the awareness of their condition came in later life. Many participants highlighted that striving to stay in balance is an important aspect of their condition.

Perception of self and images of ideal self helped further understand the nature of their problems and establish treatment aims. While participants described themselves as quiet, reserved, not confident, anxious, impulsive and interested in people, they wished they were more confident, more adventurous, less angry and feel more meaning and lightness in their lives and have meaningful and satisfying relationships with other people.

Interviews offered further understanding of usual coping strategies and resources available to participants. Most realised that involvement in satisfying activities throughout the day helped relieve their depression but they often found it difficult to engage due to low motivation. Social and family support was limited for most participants and they often mentioned family disputes or lack of understanding from relatives as factors contributing to their depression. Many participants recognised altered thinking patterns when depressed, involving persistent negative thoughts and focusing on themselves. Simple coping mechanisms like repression were used and it was noted that directing thought process on other people was helpful.

All participants had received some sort of professional mental health support at certain points in time, often in the past (support from GPs and psychiatrists, often antidepressants), and all had some experience of talking therapies, including CBT, CAT and counselling – all with varying effects. None of the participants had had experience of arts therapies before the project.

Participants expected their art therapy sessions to be challenging and a hard work, as well as a learning experience and an opportunity to relax, while “not talking but doing”. They hoped that it would offer an outlet for emotions as well as new insights and rediscoveries. Although specific expectations seemed to have been present, some participants spoke about their uncertainty mostly and avoided admitting expectations.

b) Final interviews

In their final interviews, many participants felt that the reality of therapy was different to what they had expected. However, objective analysis of comments in final interviews showed that some or most of the initial expectations were met. Participants described their experience of art therapy as valuable, interesting and challenging and shared what they liked and disliked in the process. Feelings of achievement and relief were also mentioned. Some aspects of the therapy (like being in a group and self expression) had both pejorative and positive connotations.

Certain moments in therapy were identified by the participants as carrying more meaning than others and these significant moments concerned either times when a particular personal insight was gained (like rediscovering aspects of self) or a connection or meaningful exchange between participants occurred (often triggered by engagement in discussion after art making). Often the most memorable moments indicated times when progress in therapy was made.

Outcomes of the therapy often were not immediately obvious to the participants and they reported uncertainty of the treatment effects and doubts whether the therapy had been helpful. However, further responses revealed diverse areas in which changes were acknowledged by the participants. Among these were: increased awareness of others, increased self awareness / knowledge of self / realisation of own needs, further exploration of creativity outside of therapy sessions, a sense of achievement, friendship within the group, increase of anxiety and physical implications (like less problems with sleep and headaches).

Certain themes were common and seemed most significant in participants' evaluation of the process of their therapy and these were named by the researcher as: "being in a group", "challenges of therapy", "depression as elephant" and "meaning of therapy". Being and working in a group seemed to have been the most remembered and valued and simultaneously the most distressing and unwanted experience in therapy. It could possibly be concluded that the need for meaningful connection and relationships is paradoxically met with often overwhelming anxiety. Therefore being in a group was identified as one of the biggest challenges the participants experienced alongside the difficulties with self expression and spontaneous creativity. Many participants

recognised that the subject of depression often remained “an elephant in the room” and admitted that they were often anxious or not comfortable with bringing it up for discussion, although they shared the willingness to explore the nature of depression further. The paradox of the need for deeper exploration of the subject combined with anxiety and apprehensiveness of sharing painful experiences with others was apparent.

Finally, most participants were inclined to reflect on the process of therapy and recognised that the therapy was meaningful to them although were often unable to precisely locate the meaning in context. Potential ability of art therapy to enhance creativity and motivation was considered especially relevant to depression. Areas which triggered new insights concerned openness towards others and their problems, new ideas about the essence of creativity and spontaneity and reflections on expression and awareness of emotions.

c) Follow-up interviews

Time between the final and follow-up interviews seemed to have allowed for new insights to emerge and participants shared their reflections on the process. It is apparent that the meaning of therapy became clearer with time while immediate outcomes of treatment were less obvious. Subtlety of the newly realised implications was acknowledged by participants and insights gained on self and others were shared.

4.3.3 Identification of significant themes in the therapy process: Outcomes from observation and arts-based active reflection

The researcher was present in each of nine group sessions and therefore had a unique opportunity to observe the process of art therapy and identify some of the significant moments, indicating either individual or group shifts towards meeting the aims of treatment. Observations from each session were recorded in a research journal and analysed to identify themes which the researcher felt were significant in the group therapy process. In addition, arts-based reflections (see section 3.4.5.3) enabled further exploration of the therapy process and its meaning. Both data sources were analysed and findings will now be offered.

The rest of this section will be presented in first person, while the researcher acknowledges that the findings include a significant component of subjectivity and would not want to claim otherwise or even misleadingly indicate an objective position.

4.3.3.1 Themes emerging in the therapy process

Observation of therapy sessions offered a unique opportunity to reflect on the therapy process, experience often unavailable to non-participants. These observations led to identification of themes significant in the group art therapy sessions offered in this project.

As described in sections 3.4.5.2 and 3.4.6.2, findings in the form of themes are based on analysis of notes, which in turn incorporated observations derived from the actual art making and from discussions at the end of sessions, in addition to my own reflections. Emerging themes were visually represented on a matrix (Figure 26), which, I believe, allows for an almost instant understanding of how and when they were appearing in the therapy process. It seems significant that certain themes were present throughout the course of therapy, while others had their specific place in the therapy process, indicating therapeutic progress and varying meanings of sessions.

I will now describe the themes in hope to offer an experience of travelling through an intimate process of therapy, which I was allowed to explore. I will aim to introduce themes as they appeared throughout the nine therapy sessions to capture their changing character. It needs to be noted, however, that most themes were not bound to single sessions and will be placed in text where it feels most appropriate, highlighted in bold and followed by appropriate numbers of sessions in which they emerged. Any citations come directly from my reflective journal.

4.3.3.1.1 Journey through the therapy process

Not surprisingly, at the very beginning of therapy “experimenting / trying out” (S1, S2) was a theme emerging. It included “experimenting with colours” (S3) and also meant “getting out of comfort zone” (S3). “Awkwardness” of art making in front of others (S1,

S2) and of speaking about one's artwork (S3) seemed also a natural theme in the first few sessions.

	sessions								
	S1	S2	S3	S4	S5	S6	S7	S8	S9
experimenting / trying out									
awkwardness									
exploration									
freedom / letting go									
guilt									
balance									
motivation									
effort									
decision making									
anxiety									
fears									
conflicts									
being respectful									
hiding									
tension									
layers / underneath									
avoidance									
childhood / past									
challenges / difficulties									
needs expressed									
sharing									
emotions									
expression									
confidence									
energy									
new / emerging / waking up									
movement									
changes									
mandala									
opening									
growth									
plants									
darkness and light / ambivalence									
acceptance									
insight									
awareness (of others and self)									
journey									
animals									
trapped									
close									
music									
achievement / celebration									
unfinished									

Figure 26: Themes emerging from analysis of observation in nine art therapy sessions. (Lighter shades in particular sessions indicate emergence of a theme but a lack of the idea it represented.)

The first session started the process of “exploration”(S1), which did not finish there but was present in several following sessions (S4, S6). Exploration concerned new art media in general (S1, S6), but also exploring spontaneity and letting the paint lead and follow it (S4). “Freedom / letting go” understood as an attempt to act without too much thinking and analysis, although not the strongest theme, was noticeable at the very beginning of therapy (S2).

Session S2 brought the feeling of “guilt” for not using enough colour, which seemed to have been considered desirable in art making. This was also the time when the theme of “balance” (S2) appeared. I felt that “balance” could have been one of the needs expressed in this particular session (see further), but striving for balance could have possibly been a ballast at the same time, especially paired with the themes of “experimenting” and “letting go”. A theme of “motivation” (S2) seemed important at that point and while lack of motivation was initially expected, there was a lot of courage in the group, readiness to work seemed apparent and I felt that motivation was huge. It is related to the next theme of “effort” (S2, S3), which the group was prepared to make during the therapy, including putting effort into art making itself.

First sessions of therapy also brought the theme of “decision making” with decisions about what to draw and which colour to use being very difficult at the beginning (S2). Session S3 included further difficult decisions concerning not only choosing colours but also taking decision to engage in a more challenging work and make effort. The theme of “acceptance”, or rather lack of it, emerged in session S2 with mentions of a difficulty with acceptance of artwork making being witnessed by others.

Beginning of therapy also saw a rise in “anxiety” and “fears”, which seemed to have appeared first in session S2 and remained until session S5. Anxiety in session S2 appeared in the context of little structure and session S4 saw increase in difficulties and challenge (see further), which was understandably accompanied by increasing anxiety and fear “of something to emerge”. It felt to me that anxiety was slightly relieved in session S5, when I noted that “some problems may be touched” and in session S8 one participant noticed that anxiety she/he was expecting in the beginning of therapy was relieved once she/he learned what would happen in sessions.

Rise in anxiety and fears was followed by an attempt to express “conflicts” in session S3. It felt to me that the conflicts concerned internal questions like: “Do I want to expose fears?” Although conflicts were expressed for the first time (S3), there didn’t seem to have been an acceptance (S3) of them as yet and the group reaction seemed to have been an attempt to keep status quo. Fear of the exposure of conflicts could have its origins in the group “being respectful” (S3), caring for each other, considering feelings of other group members and a tendency to “rescue” each other from challenges.

A theme of “hiding” appeared for the first time in session S2, when some of the group members decided not to turn their artwork facing others in the discussion time at the end of session. In session S3 the “tension” appeared which could not be released and meant that things could be felt hiding beneath the surface, touching it, but remaining hidden. This is when the themes of “layers / underneath” and “darkness and light / ambivalence” emerged (S3) and I noted in my journal:

“Colour underneath black and coming out. Layers. What is on the surface? What is underneath? How much am I ready to share? Do I want to expose fears / conflicts? Are colours hidden under black? Is darkness disguised as colour?”

“Tension under the surface” could again be felt in session S4, when need for “something to emerge” and a simultaneous fear of it and hiding behind the masks (‘everything is well, all is beautiful, all will be fine’) seemed to have been present. “Avoidance” (S4) of emotions and of sharing them verbally seemed apparent and the theme of “energy” (S4), or rather the lack of it, emerged.

Session S4 brought the themes of “emotions” and “expression”, as the group seemed to have been wondering: “What are we here for? How art therapy may help us express emotions?” and also “I wonder how it is to be able to do that” meaning “how it is to paint spontaneously, with no plan”. Some of the group members appreciated recognition of emotions in artwork and shared feelings of jealousy of others being able to “let go”, and express emotions through art. Possibly those emotions were this “something”, hiding under the surface and causing tension? Practicing of making decisions (S4) with slightly more confidence and acceptance (S4) of challenge seemed to be present and it is possible that the group’s readiness to make effort led to further developments in therapy process.

Session S5 saw “energy and humour lost from the group”, while there seemed to have been a “willingness to engage in a more in-depth work, to share and express emotions”, accompanied by “a strong fear and still hiding away” and “a trigger seemed needed to release these emotions”. I made a note: “Towards relaxation. Possibly needed to relieve tension and when relaxation is achieved more meaningful work may be done?” Session S5 introduced artwork making to a theme chosen by the group. While little structure seemed to have caused increase in anxiety, possibly a theme released emotions and allowed for more relaxation? Nevertheless, a thought is shared in the group: “If not given a theme, I would only attempt to paint nice pictures, I will not want to touch the emotions or problems”.

The themes of “confidence” and “journey” appeared as members of the group were taking “small steps on the journey towards confidence” (S5), which were “slowly becoming bolder and more defined”, as I noted. It seemed important that “confidence was changeable, present on one day, absent on another, it’s not given, it comes and goes, changes from rain to sun” and that “it’s good to have tools to help through the rain.”

Themes of layers / underneath” and “confidence” were still very present in session S6. Different layers were recognised in the artwork created (further explained) and “something emerging”. Emotions were finally very present, the group started noticing different shades and textures and making associations to mood and emotions, while some members were facing them for the first time. Confidence and readiness to share (further introduced) was growing in the group.

The theme of “energy” (S6) reappeared, this time literally and in the context of new energy emerging, while the group noticed how energy was present “in every image, they all have it”. The theme of “new / emerging / waking up” (S6) seemed to be dominating in many contexts. There was an exploration of new art media, new life pictured in artwork and new qualities emerging in individual members of the group, who seemed to have gathered enough confidence to start exploring aspects of themselves, which were previously hidden. “Waking up” was represented in an image of a sun which allowed to sleep better and wake up fresher and was bringing hope. “Opening”, although sensed already in session S1, became another theme in session S6 while the group decided to use previously unopened boxes with art materials and “openness and

dialogue” seemed to be present along with the new theme of “changes” (S6). Something emerging and changes were recognised in the group with an attempt to depict “movement” (S6) in several artworks.

While the theme of “growth” appeared first in session S2, when I felt the “need for growth, starting point (for something beautiful to grow)” within the group, it only fully developed in session S6, accompanied by the theme of “plants” (S6). Confidence was growing, new life and plants were growing in artwork, underneath the darkness (“they come out whether you like it or not – light will come despite the turmoil and darkness”). With so many changes and energy, a theme of “darkness and light / ambivalence” was very present in artwork. New life was surrounded by dark skies, lighter centre of an image had darkness around it, “light and colours were layered with winter, darkness – intertwined” and there was also a “calmness and turmoil amongst it”. “Mandala”, which appeared in artworks (S6), became another theme, possibly corresponding to (or representing?) growth.

Following the rich in themes session S6, session S7 seemed to have explored new ideas and given new meanings to previous themes. “Expression” and “darkness and light / ambivalence” were still present while dark colours with lighter accents were dominating (“predominantly black, but not in a darkish way, rather expressive and strong”). Theme of “acceptance” was revisited, while difficulties seemed to have been accepted and I noted that it might have brought a feeling of “satisfaction from overcoming them”.

“Insight” was identified as a theme as the group acknowledged its importance and I felt that session S7 offered new understandings. “Awareness” (S7) seemed to have been the largest theme in the session, although it appeared briefly in session S3, when the group started to “be curious of others and their intentions”. Session S7, however, brought a new depth to this theme, when growing awareness of others and the surroundings (“images, landscapes, family history, the past”) was noticed. “Showing appreciation to others, wanting to observe them, giving more attention to them” seemed apparent. Two types of awareness emerged:

“the awareness of the outside, what is happening around, and awareness of oneself, of one’s traits, skills, feelings / the inner awareness and the awareness of others, outside. Only when you are not preoccupied with yourself, not so

egocentric, can you notice what happens around you. Self- awareness is important.”

Self-awareness seemed to have grown in the group (e.g. “I know that I build walls around me, so that people cannot touch me”). Theme of “music” appeared when it was recognised as facilitating growth of awareness, “of what is happening around”.

Session S8 brought some new themes and revisited the themes of “expression”, “changes” and “growth” once more. A theme of “journey” (S8) and “darkness and light / ambivalence” emerged again. This time it was a pass through a dark tunnel and another with a light in it – “the therapy was a journey”. Crossroads appeared in another journey, as there was no certainty of “what would happen next”.

Vivid, expressive images appeared in the session. A surreal tropical scene included plants (S8) and “animals” (S8), which became a theme, as they appeared in another artwork (“the wildest animals”).

A theme of being “trapped” (S8) seemed very strongly present, in varying contexts. It related to inability to engage spontaneously in art making, but also to the wild animals being trapped, going through the tunnel, possibly the group being “trapped, together in a small, suffocating space”. Another theme of “close” seemed very much related, when the feeling of being trapped originated in “being so close to others and having to share”. The tropical jungle was also an “enclosed space, humid and crowded”. The theme of “close” seemed to have appeared for the first time in session S1, when “difficulty being in a group, so close at one table” was mentioned. However, there was an acceptance as well, while the “animals needed to accept each other in this confined space and needed to coexist in peace”.

Session S9 gave the theme of “close” another meaning, when the desire to be close to others seemed to have been explored. Possibly “close” could also relate to the closing of therapy? Music and movement appeared again in an artwork in session S9. Additionally, the theme of “achievement / celebration” emerged when it was recognised that the fact that “everyone went through therapy and completed it” deserved celebration (“there is something today to celebrate”) and was “a kind of achievement”, which the group shared (“we are all there”). A feeling that some processes were not

complete led to the last theme – “unfinished”. Artwork seemed unfinished and there was a sense that the group did not want the therapy to end.

4.3.3.1.2 Generic themes

Some more generic but not less important themes seemed to have been present throughout the therapy process and therefore did not seem to suit the chronological order of this journey, but will be introduced now.

Childhood / past

The past and childhood experiences appeared at different moments of therapy. In session S1 exploration of art materials resembled a “childlike experience, going back to childhood”. Session S3 brought memories, by “revisiting technique known from school” and artwork seemed to have been used to connect to events and feeling from the past, which again could be noticed in sessions S4 and S9, when “childhood memories” found their place in the group.

Challenges / difficulties

The theme of “challenges / difficulties” emerged in session S1 with “difficulty being in a group, so close at one table” and continued in session S2 with “difficulty with acceptance of artwork making being witnessed by others” and “difficulty with making decisions (what to draw, which colour)”. Sessions S7 and S8 seemed to have brought other challenges when difficult observations about self were made and the group themes were considered challenging.

Needs expressed

Expression of needs seemed to have started early, in session S2, and continued in different forms until the very end of therapy. Session S2 brought the need “for calm and peace” as well as “simplicity, honesty, ideal place to be and balance”. Need for “expression of emotions through art” and “need for something to emerge” was expressed in session S4, while the need to “relieve tension” and possibly relaxation

could be felt in session S5. Calmness was mentioned again in session S6, while session S8 brought in animals which “needed to accept each other” and to “coexist in peace”. In the last session, S9, a need for “something relaxing” emerged.

Sharing

“Sharing” was a theme throughout the therapy and brought various feelings with it. It appeared for the first time in session S2 (“sharing, looking from various perspectives”) and became more difficult in further sessions. Session S3 saw increase of sharing (“of pastels, of the theme, of colour”) and of recognition of looking at “the same image and colours differently, sharing different perceptions”, but it also brought doubts about willingness to share (“How much am I ready to share?”) and whether the “environment is safe enough for sharing of self”. Avoidance of sharing emotions seemed to have been present in session S4, while session S5 saw the group better prepared to “share and express” again, although this was challenging. Sharing of art materials, “recognition of common themes in artwork, dialoguing” seemed to have reached a peak level in session S6, while it could have also caused the feeling of being too close and trapped. The culminating session S9 included sharing of personal memories, which seemed “powerful” and appreciated by the group.

4.3.3.1.3 Conclusion

The described journey through the therapy process was an effect of a systematic analysis of my observations and reflections following the sessions and as such is considered a subjective account. Nevertheless, I believe that it allowed for a deepened understanding of how therapeutic change happened in this particular group art therapy for adults suffering from depression and how the unique qualities of art making (both the process and outcomes in form of images) helped facilitate the progress and new insights.

Some themes (including childhood/past, challenges/difficulties, needs expressed and sharing) were present throughout the therapy while others seemed to have been specific to particular sessions or stages in the life of the group. In a brief summary, sessions S1 to S3 included themes related to experimenting and exploration, motivation,

willingness to make effort and attempts to make decisions as well as the feelings of awkwardness or guilt. Conflicts, fears and anxiety were the themes of sessions S2 to S4, where also the themes of hiding, tension, layers and avoidance emerged. Difficulties with expression of emotions and sharing seemed to dominate session S4, while growing confidence and anxiety relieved in session S5 enabled therapeutic progress and change to happen in session S6, where new energy, movement and opening were observed and growth was enabled. Session S7 brought acceptance and insight, while awareness of self, others and surroundings increased. The metaphor of a journey emerged in session S8, when the feelings of being close, but also trapped dominated. Symbolism seemed to have been present throughout the session, while images of animals, plants and depictions of journeys served a role of representation of difficult emotions appearing in the group. An ability to generate metaphors at this level seems to indicate therapeutic progress. Last session, S9, brought the theme of achievement and the feeling of something unfinished, possibly in the context of a very brief group therapy, where additional sessions might have brought even deeper insights.

4.3.3.2 Arts-based reflection

After each therapy session, not immediately, but always within a few hours after the group finished, I took time to create, while immersing myself in thoughts about the themes which seemed significant in the session. I avoided focusing on individual members of the group or particular problems they experienced. Instead, I was trying to think about the group as a whole and about the phenomena I observed within the therapy process. Such approach helped me to deconstruct the meanings of the most intense themes rather than individual concerns, brought in by group members.

In my work I used a set of art materials similar to the one available to the group members. Not being a trained artist, I believe that my art making reflected to some extent the process, which the participants experienced. I was faced with similar resentment and anxieties in the beginning and experienced more confidence and growth with increasing familiarity with art materials and the process of art making itself.

Nine different images, which were the result of the described process of data collection, are included in Appendix 30. Once the data were collected, I decided to keep them safe and not to look at them for several months to allow for the incubation process to take place. After that time, I connected with them again and engaged in the process described in section 3.4.6.3, which led to the creation of an essence – a single image and a single, however complex, finding, presented below (Figure 27) and in larger format as Appendix 31. I felt it was important to surround myself with a variety of art materials, just as the group members were. Contrary to what I expected, I did not experience any hesitation while choosing art materials. I was changing them numerous times, often coming back to the tools previously used. The process of creation was also unexpectedly quick.



Figure 27: Final image (“essence”) created using elements of arts-based inquiry.

While the image is the actual finding, it seems appropriate to describe it verbally, which I will now attempt to do. It is also important to note that words accompanied this artwork from the very beginning and therefore I decided to layer them over the image – both visually (Appendix 31) and verbally. The image and the process of its making are metaphorically presented in the narrative below (Figure 28).

There is a centre here, a core. And a mixture of parts – separate in form, but connected. Grey is the beginning, then colours unfold. Black joins, adds definition. Eventually all colours, all shades are there. They are approaching, with energy, take turns, don't waste time. Some are stepping out with caution and subtlety. Layers emerge, one after another, covering. Then revealing. Some are hidden, some are growing under, there's life underneath, deep inside. It is reaching out. In the pre-growth shadows and light appear. Darker or lighter shades may not dominate the story, they all have place, they need to be in balance, controlled. Balancing colours, balancing forms. In and out. Towards the boundary, outside the walls, outwith. Growing.

Figure 28: Narrative to the image (“essence”) created using elements of arts-based inquiry.

The image and the text were inspired purely by the data collected (nine images) and possibly should not be interpreted. I believe that the image and the process of art making represents the essence of this project, although it emerged in response to artwork only, through the method of active imagination and no consciously intellectual activity was involved.

While I would like to avoid any definitive interpretations, consideration for scientific value of the created essence reluctantly leads me to a conclusion that the image possibly responds to the complexity of depression, its various representations, layers, paradoxes within it, anxiety and longing for connections, striving for balance and meaning. The circle, the core may also be seen as a therapy space, through which growth and breaking the walls becomes possible. In this light, the narrative may not only be considered as a description of art making process, but possibly as an essence of the therapy process itself. The process of art making may simply illustrate the process in therapy. This possibly explains why it seemed especially crucial to me to include the narrative to accompany the image: While the outcome is important, it should not be considered separately to the process - a notion commonly recognised in arts therapies realm and adding another layer of meaning to the created essence.

4.3.4 Assessment of changes in depressive symptoms: Outcomes from questionnaires

Results from questionnaires completed by participants before and after therapy, as well as in follow-up, were analysed. Scores for each questionnaire were compared in combinations as follows:

- Pre therapy (“initial” measurement) with post therapy (“final” measurement)
- Pre therapy (“initial” measurement) with follow up (“follow-up” measurement)

Additional comparisons were performed on initial and interim scores as well as interim and final scores of PHQ-9, for which such data was available.

Since due to small number of participants parametric tests could not have been used, a series of null hypotheses assuming equality in the median of differences between mentioned scores were tested using non-parametric related samples Wilcoxon test. Figure 29 lists the hypotheses and the results of testing, which are further described.

Null Hypothesis	Sig.	Decision
The median of differences between PHQ9initial and PHQ9final equals 0.	.042*	Reject the NH
The median of differences between PHQ9initial and PHQ9interim equals 0.	.042*	Reject the NH
The median of differences between PHQ9interim and PHQ9final equals 0.	.279	Retain the NH
The median of differences between PHQ9initial and PHQ9follow-up equals 0.	.043*	Reject the NH
The median of differences between GAD7initial and GAD7final equals 0.	.492	Retain the NH
The median of differences between GAD7initial and GAD7follow-up equals 0.	.197	Retain the NH
The median of differences between WHO5initial and WHO5final equals 0.	.223	Retain the NH
The median of differences between WHO5initial and WHO5follow-up equals 0.	.068	Retain the NH

Figure 29: Null hypotheses tested with Related-Samples Wilcoxon Signed Rank Test (significance level of <.05 highlighted).

Figures 30, 31 and 32 present individual participants’ scores on the three questionnaires measured in four (PHQ-9) or three points in time (GAD-7 and WHO-5). Graphs offer an immediate visual assessment of trends in the scores.

4.3.4.1 Assessment of changes in depression levels (PHQ-9)

Statistically significant differences between initial and final, as well as initial and interim scores (both $p=.042$) in PHQ-9, suggest that the level of severity of participants' depression decreased after the course of art therapy. The decrease in depression levels remained equally significant ($p=.043$) in the follow-up assessment (as compared to initial scores). For all participants the final and follow-up PHQ-9 scores were lower than the initial measurement. In addition, two of the participants, whose depression was initially relatively mild, did not present symptoms of depression in their final and follow-up assessments (score lower than 5).

A general trend towards decrease in depression levels may be observed in participants' individual scores (Figure 30). The effect seems to be more linear for participants whose depression was initially mild (P4 and P5), more complex for participants with initially moderate depression (P2 and P3) and less obvious for participant, whose depression was initially more severe.

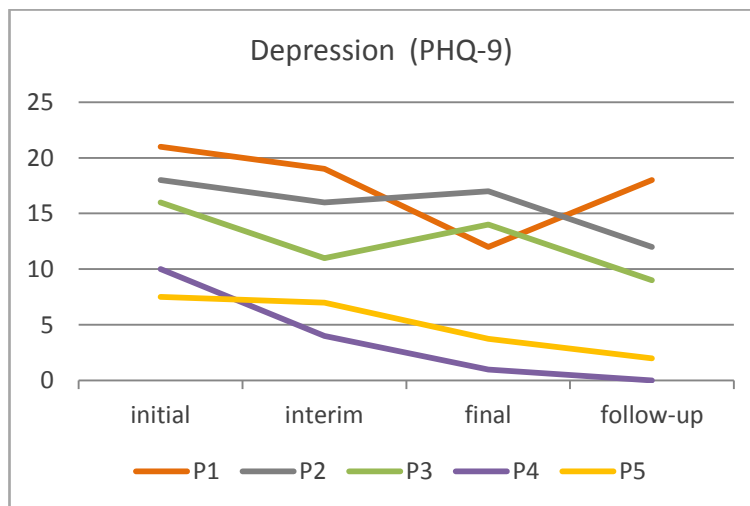


Figure 30: Individual scores on PHQ-9 measured in four points in time: pre therapy ('initial'), during therapy ('interim'), post therapy ('final') and in follow-up (follow-up). ('P' indicates individual participants.)

Although the sample was too small to allow for generalisation or even estimation of the effect size, a statistically significant tendency of depression scores to lower following the therapy is observed. While this study did not include a control group, it may not be concluded whether the effect occurred as an implication to therapy or whether it was

due to other reasons, including possible spontaneous recovery from depression (Ankarberg & Falkenström 2008).

4.3.4.2 Assessment of changes in anxiety levels (GAD-7)

No statistically significant difference was found between initial, final and follow-up scores in GAD-7. Results were mixed for different participants, with three members of the group showing decrease and two members increase in anxiety levels at the end of the therapy (see Figure 31). Both participants, whose anxiety increased during the project, showed a slight decrease of depression levels. In the follow-up assessment, four participants revealed lower levels of anxiety in comparison with measurements pre-therapy, while one participant scored higher than in initial assessment.

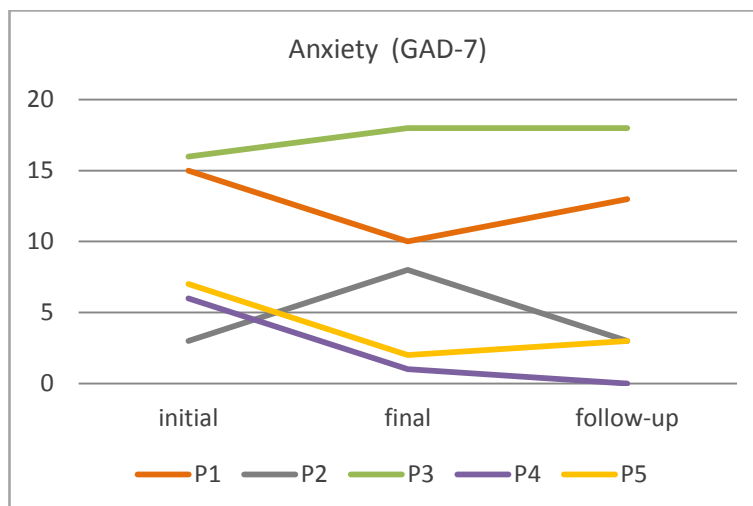


Figure 31: Individual scores on GAD-7 measured in three points in time: pre therapy ('initial'), post therapy ('final') and in follow-up ('follow-up'). ('P' indicate individual participants.)

The increase of anxiety may be a temporary effect of the therapy, which was possibly too brief to adequately support participants, who may need longer time for benefiting from the treatment. Supposing that the course of therapy was too short to offer substantial improvement, it is possible that the therapy ended when some of the participants were experiencing increased anxiety, often expected in the middle of the treatment. If this is the case, a longer therapy time would quite likely allow to calm down those anxieties by the time the therapy would be concluded. Alternatively, the effect

may be an example of a common in psychotherapy phenomenon that an approaching end of treatment itself, regardless its duration, causes an increase of anxiety, when facing reality outside of therapy room becomes inevitable.

4.3.4.3 Assessment of changes in general well-being (WHO-5)

No statistically significant difference was found between initial, final and follow-up scores in WHO-5. However, four out of five participants reported improved well-being and an increased satisfaction with life immediately after their therapy, while those factors lowered for one participant (see Figure 32). In the follow-up assessment four participants revealed an improved well-being in comparison to the pre-therapy state, while no change was observed for one participant. These results were additionally complemented by interviews. Although observed changes were not statistically significant, a possible trend towards improvement in wellbeing, especially in longer term (in follow-up, 10-11 weeks after therapy), may be observed in Figure 32.

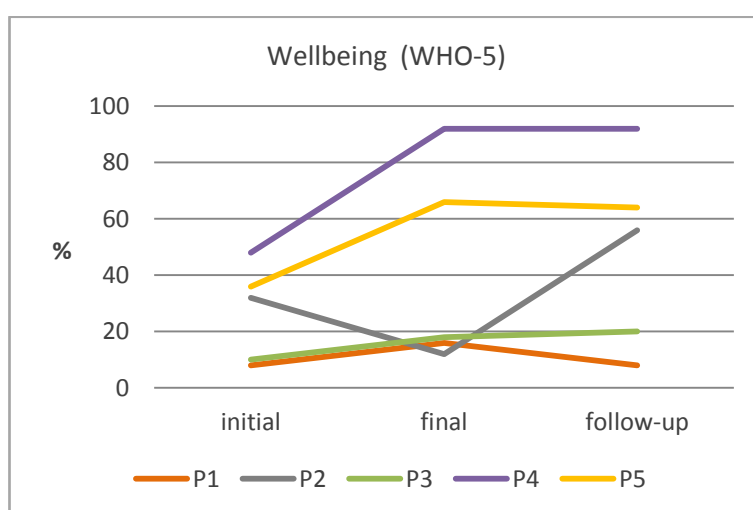


Figure 32: Individual scores on WHO-5 measured in three points in time: pre therapy ('initial'), post therapy ('final') and in follow-up ('follow-up'). ('P' indicate individual participants.)

4.3.4.4 Summary

While no scientific conclusions may be drawn as to whether the art therapy or other factors impacted changes in the levels of depression, a trend was observed for

depression scores to lower immediately after the therapy and remain on similar or even lower levels until the follow-up assessment. Such statistically significant results are promising while they open an area of further research exploration. The lack of control group neither allows for quantitative evaluation of the intervention nor for assumption of its benefits for relieving depression. However, the tendency of scores to lower following the therapy, clearly indicate that the intervention did not cause harm.

The results concerning anxiety and wellbeing are inconclusive, while no statistically significant differences were found between pre and post therapy scores. No confirmation of an impact of therapy on these factors does not, however, equal an absence of such influence. In the follow-up improvement of subjective wellbeing levels was noted in the scores of four out of five participants while decrease of anxiety levels was noted in the scores of three out of five participants.

4.3.5 Making connections: Offering an evaluation

Phase 2 of this research aimed to evaluate arts therapies as a treatment option for depression. Eventually, a brief art therapy group for adults suffering from mild to moderate depression was evaluated. While it is recognised that only the value of this single group intervention in a particular setting and time could have been assessed and no attempts to generalise are made, it is believed that the findings presented above might serve as an example evaluation of arts therapies intervention for depression.

Since the findings stemmed from complex analyses of very different datasets, it is important to bring them together and an attempt to offer meaningful connections will now be made. Core insights from an evaluative phase of this project will be presented below in separate points, for clarity. It needs to be noted that these conclusions should be placed within the context of this particular group art therapy only and do not claim to offer evaluation of arts therapies practice in general.

1. A statistically significant decrease in depression levels, assessed using relevant questionnaire, was noted immediately after the treatment and in 11 weeks follow-up in all five participants attending brief group art therapy. Improvement

in perceived wellbeing was noted by four participants immediately after the therapy and in 11 weeks follow-up, although the effect was not statistically significant. No significant effects of therapy on levels of anxiety were noted, while it increased for some participants and decreased for others.

2. All five participants completed the full course of treatment and attended interviews at three points in time. The fact that participants needed to take initiative to sign up for their therapy (autonomous motivation) seemed to have explained their heightened motivation to complete treatment and willingness to engage in challenging aspects of the process, as reported by participants and observed by the researcher.
3. Participants shared that their experience of art therapy was generally valuable and interesting but also challenging. Their expectations of therapy were only partially confirmed, while the reality of treatment proved surprising for some participants. Initial expectations were for the therapy to be: a challenge, a hard work, an outlet for emotions, a learning experience, a rediscovery and a luxury and relaxation. Participants also expected to be “not talking but doing” and to gain insights.
4. Art therapy sessions brought some memorable experiences which participants shared in their final interviews. Significant, best remembered, moments in therapy concerned two areas: 1) rediscovered aspects of self / increased knowledge of self and 2) increased connection or meaningful exchange between the group members, which seemed to have led to progress in therapy.
5. Participants admitted that aims of therapy and how it may be helpful in the treatment of depression were not clear to them immediately after the course of nine sessions. For most participants insights into the meaning of their therapy became available later and shared in follow-up interviews. The time between end of therapy and follow-up interviews (approximately 11 weeks) seemed to have allowed for the experiences to consolidate and enabled deeper understanding of the therapy process. Meanings of art therapy for the participants included:

- a) enhancement of creativity, spontaneity and motivation
 - b) acceptance of own feelings, which need to be experienced in therapy
 - c) expression of emotions, “getting things out”
 - d) increase of openness towards others, willingness to share and realisation how others may be helpful
 - e) acceptance of depression.
6. Among the outcomes of therapy mentioned by the participants were (in order of most commonly reported):
- a) increased awareness and appreciation of others
 - b) increased awareness of self / knowledge of self
 - c) sense of achievement
 - d) willingness and readiness to further explore own creativity
 - e) friendship born within the group
 - f) increase of anxiety
 - g) Improvement in physical symptoms (better sleep, less headaches).
7. Participation in the therapy, as mentioned before, was considered challenging by participants and the two main areas of their difficulties concerned: 1) being in a group (difficult to make art in front of others and to share feelings in discussion at the end of sessions), 2) self-expression (difficult to be spontaneous in using art materials and to decide on the content of an artwork).
8. The theme of “being in a group” seemed to have been especially important in therapy process and recurrent in findings originating from most sources of data used in this project. There seemed to be a conflict between participants’ willingness to share and open towards others (will to relate) and their inability to do this, while it caused fear and presented challenges (tendency to isolate). Observation brought additional insight into this paradox, as it seemed that being in a group (or connecting) is both desired and causing a feeling of being “trapped”, too close to others. However, an increased readiness to share and open towards others was observed in the last sessions and is considered an effect of the progress in therapy.

9. Another theme highlighted by the participants concerned the nature of depression and avoidance of the subject within the group (depression as an “elephant in the room”). Again, there seemed to have been a conflict, while participants were willing to explore the topic of depression further and unable to initiate discussion in fear that this would cause distress in the group. A similar sense of “something hiding underneath” and layers covering emotions which need to emerge was also revealed in observation and arts-based reflection.
10. Other findings from observation and arts-based reflection confirm the themes already mentioned (e.g. achievement, awareness of self and others, insight, anxiety, self-expression, acceptance of own feelings) and bring insight into the process of art therapy and how it developed over the nine sessions of brief group intervention. A clear progress in the group exploring significant themes is literally visible in Figure 26. An image (Appendix 31), the finding resulting from the engagement in art-based reflection, seems to offer additional level of understanding by metaphorically exploring both the process of art making and the process of therapy.

Although the limitations of this project do not allow for claims on the therapy’s effect, the study design incorporating a variety of methods enabled a comprehensive evaluation, indicated changes following the treatment and hopefully enhanced understanding of how they might have been achieved, provided they were the outcome of the therapy itself. It has been already recognised that the offered evaluation may not be extrapolated to arts therapies practice with depression in general, but intends to provide insights into the therapy process in a particular brief group art therapy intervention.

Brief summary:

A brief group art therapy may be a safe and valuable intervention for adults suffering from depression. While it remains unclear whether the therapy is effective, it has proven not to be harmful for the participants and may potentially allow for a number of benefits, including decrease in symptoms of depression and improvement in subjectively

perceived wellbeing. Areas of psychological wellbeing which may potentially be enhanced through arts therapies include an increase of: acceptance of depression and its challenges, creativity and readiness to express emotions, sense of self and awareness of others, readiness for meaningful communication and relationships. Additionally, arts therapies may potentially bring a sense of achievement, a sense of balance and new insights and may facilitate growth and finding meaning for adults suffering from depression. However, arts therapies practice with depression is demanding and brings challenges to both the therapists and the clients. It is thus important that therapists understand the concepts core to depression and likely to play a vital role in the therapy process (e.g. time, layers of symptoms covering the main problem, the feeling of being trapped, the need for hope and relaxation to relieve initial tension).

4.4 Assessment of feasibility of a larger study

In addition to determining clinical outcomes, this pilot project enabled assessment of feasibility of a larger study and this will now be presented. Although the pilot did not include a control group, as initially planned, and the number of participants was smaller than intended, the reasons for these necessary adaptations were explored and conclusions drawn. Thus, the value of this project lies not only in the measurement of outcomes but also, and possibly primarily, in the fully used opportunity to observe and analyse the challenges in aim to efficiently plan and successfully conduct a larger study.

It needs to be highlighted that the assessment of feasibility was based on data collected from various sources, including: a) participant observation, b) informal conversations with the therapist and c) final and follow-up interviews with the participants. In particular, accounts collected through interviews were essential for the evaluation of the intervention, including its safety, acceptability and accuracy for the needs of adults suffering from depression (see sections 4.4.5 and 4.4.6).

The assessment of feasibility included several components, based on Thabane et al. (2010) and Lancaster et al. (2004), which will now be listed and discussed.

4.4.1 Assessment of recruitment potential

Recruitment for this study had three separate stages, including preparation, advertising and undertaking interviews.

An aspect of the recruitment procedure, which especially needed to be tested for its feasibility, was the self-referral of participants to the project. In response to adverts, potential participants were expected to express their interest in the study by contacting the researcher through e-mail. Figure 33 illustrates the flow of participants through the project and actions undertaken by both the participant and the researcher are used as indicators of points in time crucial for completion of therapy and engagement in the research. Participants could potentially withdraw from the study at any of these stages. Out of 12 potential participants, who contacted the researcher in the advertising period, seven attended initial interviews (stage 5), while five withdrew from further contact.

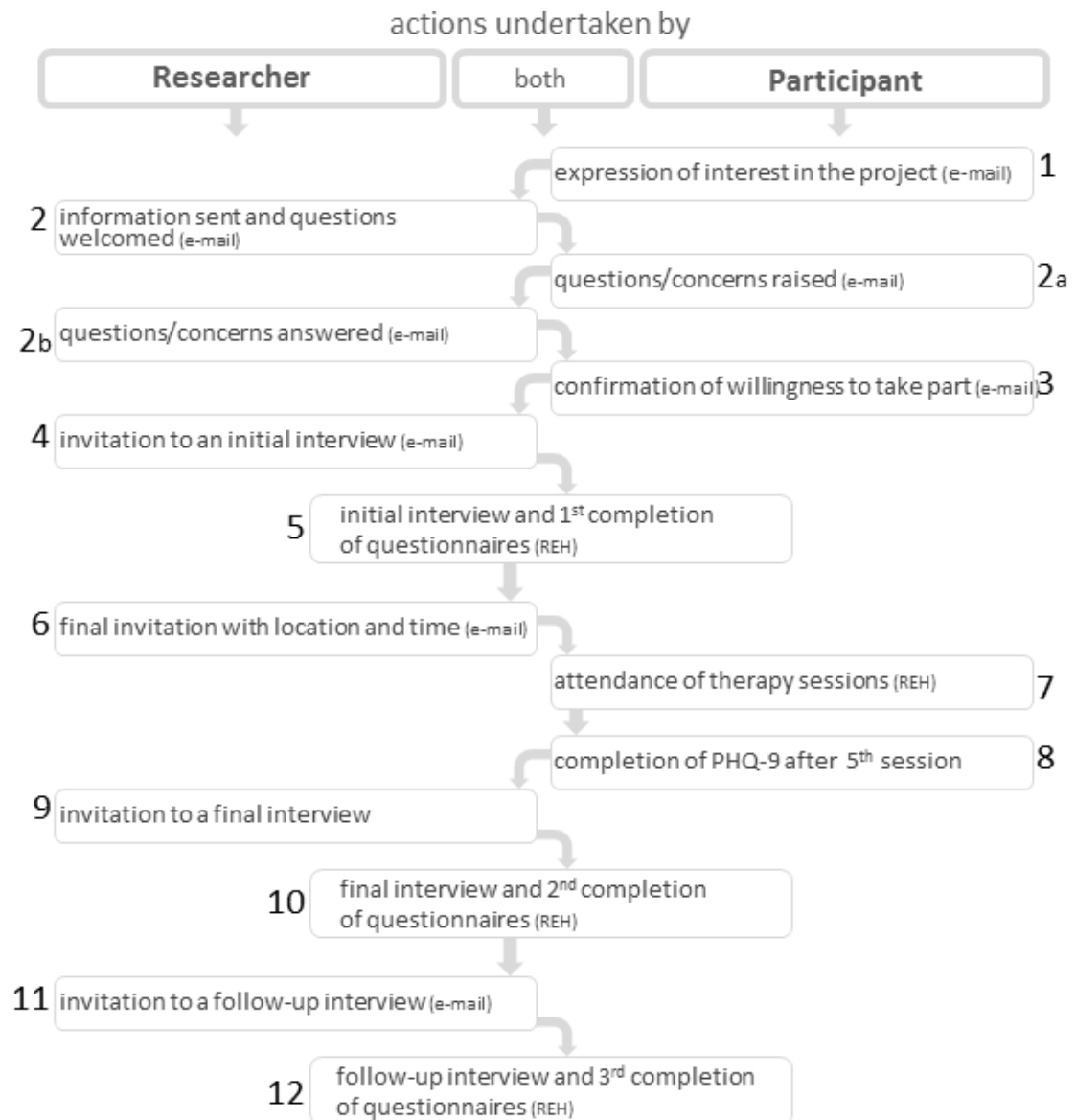


Figure 33: Participant flow through the study.

Initial interviews took place over the period of two weeks (1st – 15th February) and all potential participants, who attended, agreed to sign the consent form (n=7). However, once the exact dates and times for the therapy were announced, not all potential participants were able to join the group due to other commitments on those days and eventually the project recruited five participants.

The initial hope for this project to recruit enough participants to form two treatment groups and a control group, has unfortunately failed. However, should several conditions around recruitment procedure changed, the plan could have been more successful. While interest in the project was expressed by many more potential participants after the recruitment stopped, it could be assumed that more time would increase the recruitment rates. Moreover, advertising of this study could have been relatively easily improved, by expanding the number of researchers or research assistants. A single person could access only a fraction of places, where interest in the study could be generated, and therefore direct advertising was geographically limited to the city centre of Edinburgh only. At least twice as many relevant services were identified in other areas of the city and the area for recruitment could potentially be expanded to areas further surrounding Edinburgh. Thus, a more comprehensive and extensive advertising could likely result in higher recruitment rates. While two weeks of relatively simplistic advertising ensured commitment of five participants, a more thorough procedure could potentially result in recruitment of 30 participants in around 6-8 weeks.

This figure is additionally based on the fact that the advertising, however modest, was received well in the community. Interest in the study and arts therapies as treatment method was expressed not only by potential participants themselves, but also by their relatives. While it could be expected that sufferers of depression might not be able or motivated enough to initiate contact with the researcher, this study has demonstrated otherwise. Based on data collected in interviews, the procedure of self-referring was indeed welcomed by the participants, who stressed that it offered them an opportunity to take control over their depression and presumably could have been a step towards increase of self-confidence.

Zuroff et al. (2007: 137) reported that autonomous motivation defined as “the extent to which patients experience participation in treatment as a freely made choice emanating from themselves” was the strongest predictor of outcome and even stronger than therapeutic alliance. Autonomous motivation seemed an important factor in strengthening participants’ commitment to therapy in this study. It needs to be noted, however, that this project was concerned with mild to moderate depression only and such effect might not have occurred if severe depression was researched.

Communication through e-mail was generally accepted by those, who contacted the researcher, but a preference for additional method of contact (e.g. telephone) was also expressed and the lack of it could have potentially limited the number of initial contacts. It may be therefore recommended that any similar future studies offer participants a choice of contact method, including telephone, e-mail and possibly a postal address, to increase recruitment potential.

Advertising through multiple channels and targeting diverse population, by placing adverts in community and health services, could potentially result in a group of participants not homogeneous enough to meet expectations of an experimental study. However, in case of the presented pilot, such approach ensured relatively fast recruitment and offered a chance to test multiple methods. The group of seven adults, who gave their consent, reported that they found out about the project from a range of sources, used for advertising, including the NHS, voluntary organisations, community centres and browsing the Internet. No single source seemed dominating, but the sample is too small to draw any conclusions regarding the most efficient of the recruitment channels. It seems, however, evident that recruitment through various modes and settings increases the potential for higher numbers of participants in studies on mild to moderate depression, presumably because of high prevalence of this condition in a population of otherwise healthy adults and across social backgrounds and lifestyle choices.

It should be noted that, despite a small sample, consent rate in this pilot reached 100 %, while all potential participants, who attended the initial interview (n=7), agreed to give their consent. Since two of the potential participants were lost to further stages of the project due to other commitments, in future studies more flexibility with days and times of therapy could be considered. Preferences among potential participants could be assessed in initial contact and times of sessions adapted accordingly. Alternatively, if flexibility cannot be offered, specific times and dates could be announced to potential participants before they attend initial interview. This would ensure the best use of researcher's time and as little as possible disappointment for potential participants, who would not be able to commit to specific dates. It is understood that randomisation procedures might prevent from disclosing exact dates of therapy to participants. Nevertheless, the fact that a significant number of participants, who gave their consent,

may not be able to attend therapy due to other commitments needs to be accounted for while designing a randomised trial.

Based on the presented pilot, it may be assumed that flexibility with time and dates of therapy would result in a higher compliance and participants remaining in the study. The described issue seems especially relevant to adults suffering from mild to moderate depression, who are likely to live relatively stable lives and have work and family commitments, unlike sufferers of more severe mood disorders.

4.4.2 Assessment of retention rates

This project managed to attract participants enough for them to remain involved with the study until its completion and including the follow-up (completion rate was 100%, with all five participants completing every stage of the project). Participants also agreed to engage in all parts of the project, attending therapy sessions and completing questionnaires, as requested (compliance rate was 100%, with all five participants agreeing to be involved in all stages of the study).

While all participants agreed to attend therapy sessions, every absence was recorded. Throughout the treatment there were 39 attendances out of 45 possible, which allows for a conclusion that attendance rates were excellent (87%). Moreover, out of six absences only three were unexplained while other three followed a notice given in advance (unexplained absences constitute under 7% in overall attendance). Low attrition rates were also reported in studies of music therapy for depression (Maratos 2008).

Failure and success rates in this project require a complex assessment, separate for every outcome measure. Reduction in depressive symptoms achieved a success rate of 5 to 0 in both the final and follow-up assessment. Increase of general wellbeing was observed in 4 cases in final and follow-up assessments (success rate of 4 to 1). Results in levels of anxiety were mixed, with 3 cases with decrease of symptoms and 2 cases with either unchanged or increased anxiety (success rate of 3 to 2). Generally, success rates were high in reduction of depression and lower in other outcome measures.

4.4.3 Assessment of appropriateness of eligibility criteria

Eligibility criteria in this study were relatively open to allow for inclusion of members of general community rather than creation of a more artificial site or background specific sample. The most significant criterion was an appropriate level of depression. As intended, this was measured using the PHQ-9 questionnaire and accompanied by an interview serving the purpose of an initial assessment. This dual approach to measurement of the level of depression proved effective and the interviews were often useful in verifying quantitative measurements. Most often they complemented a PHQ-9 score, while in two cases especially the interviews explained the level of depression more thoroughly than the questionnaire and offered additional insight in its nature.

In one of the mentioned cases, a participant who presented her/himself well and showed the level of functioning typical of a moderately depressed person, scored particularly high on the scale (score of 21 points), placing her/him on a severe spectrum of depression. The interview verified this false positive score to confirm that the participant's condition, although undoubtedly clinically significant, could be better placed within the moderate spectrum. In another case, a participant scored relatively low in PHQ-9 (score of 7.5 points), which seemed a false negative score after an interview was conducted. In both cases psychological traits and learned behaviour habits seemed to have lead to participants' tendencies to respond according to assumptions of expectations in the project and according to willingness to either highlight own vulnerability or present own resiliency. A false negative score may alternatively indicate difficulties with acceptance of depression (Kendrick 2009).

In both cases, researcher's supervisor, a consultant psychiatrist experienced in depression, was consulted and offered advice as to appropriateness of inclusion of these participants in the study. As demonstrated here, an initial assessment proved essential in making decisions regarding participant inclusion and offered more insight into the nature and origins of various types of depression present in the group.

Apart from accuracy of PHQ-9 scores, other issues with regards to eligibility criteria were observed. While the study concerned a wide range of depression and included mild, moderate and moderately severe levels, it resulted in a small group of participants with very different therapeutic needs and aims. This was highlighted by three of the

participants in their final interviews and an assumption can be made that a more homogeneous group, with a narrower scope of severity, would potentially benefit participants and enable faster and more effective progress by focusing more on the common aims, easier to identify for a group sharing similar levels of depression. A similar observation was made by Ritter and Low (1996: 256), who noted that tailoring therapy “to a group of patients with similar symptoms may be more effective”. Therefore, it is recommended that future research focuses on either mild or moderate depression separately, which would not only increase methodological reliability, but also enable participants to potentially experience a therapy more tailored to their individual needs.

4.4.4 Assessment of resources

This project attempted to make best possible use of available resources which were, however, limited. A detailed analysis of whether and how this had been achieved and recommendation to increase certain resources in a larger study will now be presented.

4.4.4.1 Time management

This study has been planned for long before it could begin. Several reasons led to serious delays, which will now be commented on. First of all, while the project was conducted within NHS Lothian, specific ethical approvals and certificates needed to be issued, which took much longer than initially anticipated. Although the knowledge gained through undertaking of this study would allow for a more efficient use of time in future research, some of the procedures would require a similarly lengthy process. In further comments distinctions will be made between stages which potentially could and could not be accelerated in any future studies.

The choice of NHS setting for this project was made for various reasons, presented elsewhere (section 3.4.2.4). While such decision was believed to be beneficial for the research and the participants, it brought challenges, which would easily be avoided should the group be facilitated in the community, including voluntary organisations. Nevertheless, important lessons were learned and potential for further arts therapies research within NHS was explored.

This project gained an ethical approval from the Queen Margaret University in November 2011 and was followed by attempts to obtain an ethical approval from the local NHS Research Ethics Committee, which was eventually granted in September 2012, with conditions (see Appendix 16). Irrespective of ethical opinion, an approval from the Research and Development Office for NHS Lothian was sought and granted in August 2012. Obtaining of both approvals required much of researcher's time and attention and proved to be a challenging test of organisational skills. The application itself took much effort and time to complete.

More importantly, the researcher encountered uncertainties which could not be easily addressed by her supervisors nor the advisors from the University. It was learned that applications for ethical approval are considered on a very individual basis and, while no similar study was ever conducted in the University, there was not enough knowledge about the procedure of application and areas which should be looked at especially carefully. Therefore, amendments needed to be made to the application, which was initially rejected following the first Research Ethics Committee meeting. It was also observed that the membership of the Committee did not include professionals from the fields of mental health or psychotherapy and it is believed that this might have led to particular cautiousness in granting the ethical approval. While the Committee did not seem to trust in the researcher's ability to administer psychological tests despite her qualification as a psychologist and her relevant clinical experience, an expert knowledge and support of the application by one of the supervisors, a consultant psychiatrist, proved especially helpful.

Simultaneously to the described process, an approval from the Research and Development Office for NHS Lothian was sought and was received relatively quickly. It did specify that the researcher would be expected to apply for a Research Passport (or Honorary Research Contract) before any study procedures may begin. The application was only possible following the two approvals and only after the ethical approval has been granted, it became clear that it is a requirement of an Honorary Research Contract that the researcher holds a PVG (Protecting Vulnerable Groups Scheme) certificate, which she did not. Application process to obtain the certificate lasted nearly three months and successfully concluded just before the project was due to begin and issuing of an Honorary Research Contract followed soon.

Additional challenge presented itself when it became clear to the researcher that every person working directly on the project, who is not an NHS employee, would need to obtain a separate honorary research contract. Therefore, a potential art therapist willing to facilitate therapy in this project would need to either be employed within NHS or ready to apply for an honorary contract. Should the knowledge be available to the researcher in the early stages of the project, sufficient time could have been allowed for recruitment of arts therapists to include time and effort needed to obtain the mentioned contract (which could take up to six months). In the current study the researcher was faced with necessity to limit the recruitment of therapists to those, who had already been employed by the NHS. This proved an effective strategy, as a suitable therapist was found within the Royal Edinburgh Hospital's employees. However, similar limited recruitment process is not recommended in future studies and it is advised that potential therapists are approached early enough to allow for applying for any necessary approvals in time. This is due to the fact that not many arts therapists work in the NHS and recruitment within the healthcare system only would likely limit the chances of identifying therapists most suitable for a particular project concerning specific client group or intervention.

The entire process of obtaining all necessary approvals and certificates took eight months, a lot of researcher's time and effort and support from the research team. While it should always be expected that such complex validation of a very individual case must take long time on the reviewers' side and in administration, it is acknowledged that certain knowledge could have improved the speed of this process and spare a lot of difficulties on the way. Firstly, an extended availability of consistent knowledge regarding NHS approval systems in higher education institutions would help researchers to avoid mistakes and plan the timing of the application better. Secondly, an improvement of information specific to mental health non-pharmaceutical studies would enable more transparency into the procedure of application. It is understood that psychotherapy research in a mental health setting is undertaken relatively rarely and therefore neither extensive knowledge within universities nor information from the NHS is commonly available. It is hoped that with the development of psychotherapy research, studies similar to the one described would receive a more suitable support.

While the presented difficulties put much pressure on the timing of this project, other aspects of time management will now be reported on. Although one researcher worked full-time on the project, her time was shared between this study, the analysis of phase 1 of this research and teaching/administrative responsibilities and therefore its amount may only approximately be assessed. However, since the process of designing the project and gaining necessary approvals demanded time, it would not be much accelerated could the researcher dedicate more time to this single study.

A significant part of the preparation process was the development of a treatment manual, which happened simultaneously to obtaining approvals from the NHS. This part of the project proved time consuming and in future research it is recommended that a team of professionals is involved in similar procedures to include more expertise and reduce the amount of time required for production of a meaningful manual. Also, the manual created for the purpose of this project could, with some improvements, be potentially utilised in similar projects in the future.

Once the project had started, time management became less of an issue as the thorough preparation allowed for realistic predictions in terms of time required for certain procedures. Ideally, more time would be allowed for the recruitment process, which was delayed due to challenges around approvals. At least one month recruitment would most likely enable a creation of a control group. However, the actual scale of this project meant that the researcher could relatively easily attend to all its stages and spend enough time on each, enabling the study to proceed smoothly and with due consideration for participants' individual wellbeing and satisfaction.

Responding to potential participants' questions via email and telephone required several hours time over the recruitment period and further in the research, when inquiries were still being received after the therapy has started. Seven initial interviews, conducted over the period of two weeks, lasted for between 50 and 70 minutes each. This time included completion of the questionnaires, which took between 4 and 10 minutes. Five final interviews were conducted in a single day, each lasting for up to 60 minutes, including completion of questionnaires. Follow-up interviews were spread over the period of two weeks and lasted for between 30 and 50 minutes each, also including completion of the forms. (It is worth noting that four follow-up interviews took place

and that one participant, who found it difficult to attend the meeting, agreed for the communication to happen through email and post.)

A small number of participants in this project allowed for one researcher to offer enough attention to administrative, clinical and specifically research duties. However, should similar project be attempted on a larger scale, one researcher would not be able to attend to all tasks effectively. For a successful conduct of an RCT research assistants would need to be employed to provide support at various stages of the project, but most importantly in participant recruitment process. In this project the researcher strived to be extremely flexible to adapt to times and dates most convenient for participants for their interviews. Similar flexibility is recommended in future studies.

4.4.4.2 Capacity and willingness of the setting

This project could not have happened without the support received from the staff of the Royal Edinburgh Hospital, especially from the Outpatients Unit and the Occupational Therapy Department. Within the setting, there was a general acceptance and interest in this study, presumably as a project supported by the researcher's supervisor, an employee of the hospital. Apart from moral support, two types of physical spaces were required for the project within the setting: 1) a flexible office space for conducting interviews with potential participants and 2) a spacious and quiet room suitable for arts activities. It was soon discovered that both types of spaces were available in the Hospital and there were professionals willing to offer help with arranging suitable times for both activities. Approvals from Heads of Departments were sought and further communication happened directly with the Reception of Outpatient Unit and with senior occupational therapists within the OT Department.

Outpatient Unit was considered suitable for initial face-to-face contact with potential participants and the Unit could offer office spaces for booking throughout the recruitment period and also during the follow-up. The Reception staff were helpful in arranging times for interviews. However, the times/dates could not always be flexible enough to adapt to the most convenient times for the participants. While it was decided that the more flexibility was offered to potential participants in arranging initial interview, the more successful the recruitment could be, the researcher aimed to be

able to use the office for as much time during the working week as possible. In practice, office spaces could be offered for two or three days of the week, either for a full day or several hours, which proved enough for the scale of this project. However, for a most effective recruitment for a larger study, an office room would ideally need to be available at all office times and flexibility from researcher(s) would be required in arranging interviews.

Occupational Therapy Department within the Hospital kindly offered their art room and the relaxation room for use for the purpose of this project. Eventually, the art room was used for facilitation of therapy sessions and the relaxation room proved convenient for the final interviews. The spacious, quiet, light and safe art room met all the criteria of a suitable therapy space. It had useful separate areas for art making and for sitting and talking in the circle and enough room for securely storing the artwork and art materials, as well as tools cleaning area and fresh water facility. The relaxation room could potentially be used for movement therapy, should it happen as initially planned.

To sum up, both Departments of the Hospital were very willing to accommodate this project within their busy timetable. It is believed that a larger study could as well be accommodated in the setting, provided arrangements are made early and Hospital employees are included in provision or consultancy on the project. In addition, both office and therapy spaces were relatively easily accessible for participants, who all considered the commute acceptable.

4.4.4.3 Equipment

This project did not require special electronic equipment, apart from a computer for data storage and analysis. Also, a digital voice recorder was used for recording initial and final interviews. While this equipment was provided by the University as needed and not for the sole use of this project, it was not always available. In future similar projects it would be more convenient to have a digital voice recorder available at all times.

For the art therapy group, art materials were required and bought using the researcher's bursary budget. Total amount spent on art materials and folders for storing art work

was under £130. For a larger project, this sum would need to be more substantial, possibly allowing £10-15 for each additional participant.

4.4.4.4 Research tools

As part of data collection, this project used a battery of three questionnaires, chosen for their validity/reliability and suitability to assess the condition in question as well as correlated personal features. All three tools proved to have been easy to use and not too overwhelming for the participants. The questionnaires were paper-based and could be completed during interviews within less than 10 minutes. However, a weekly completion of the PHQ-9 was planned which was eventually limited to just one collection in the middle of the course of therapy. This was due to difficulty with fitting the collection process in the therapy session. Neither before nor after the session seemed a suitable time for completing questionnaires without distracting participants from the therapy process. Breaking of the process by focusing on the questionnaire was considered to have possible detrimental clinical implications by both the therapist and the researcher. Therefore, should a system of phone text reminders be used in the project, a weekly data collection with no distracting consequences could still be possible. A potentially useful system for submitting weekly mood ratings by text or email has been recently developed by a research team from Oxford (Foster et al. 2011).

In general, the questionnaires seemed clear and easy to understand for the participants. There were only a few requests for clarification. Participants did not require much time for filling in the set of questionnaires and the time on three occasions seemed similar for individual participants. On average, completing all three questionnaires required about 8 minutes (and varied between 4 and 12 minutes). One participant tended to give answers falling in between items on a scale, which was difficult to score later. In any future projects, it might be beneficial to state clearly that the answers should fall on the scale and in case of any doubt, one of the most accurate options should be chosen.

Semi-structured interview schedules proved helpful and included questions, which allowed for both, collection of the basic details about participants and a more advanced assessment of psychological state and personal history. Open ended questions offered an opportunity for sharing of a deeply personal material, while not putting too much

pressure and expectations on participants. Trying out three different interviews types helped to detect flaws in interviews schedules, which, it is now considered, could be improved. Initial interview could have included more specific questions to allow for functional assessment of three main life areas: personal, social and occupational. While the information was in most cases successfully collected, more specific questions could have triggered more accurate responses and make the process of diagnosis easier and resembling usual clinical practice in a mental health setting. Also, more specific questions on previous therapies undertaken and medication currently prescribed would ensure that the data is not missed. Final interview schedule seemed to work very well and offered answers to all areas of interest to this research. Similarly, the follow-up interview, which was even less structured, proved to offer a natural and honest way of closing participants' involvement in the research. The questions asked were more tailored to the style of individual participant and allowed for collection of open and spontaneous accounts. It is recommended that similar procedure is adopted in future studies.

4.4.5 Assessment of safety and acceptability of the intervention

The form of therapy offered in this project was generally accepted by the participants, which is clearly visible in retention and completion rates. While the final interviews revealed that engagement in therapy process was far from easy and participants shared which areas of therapy they found most difficult (see section 4.3.2.1.2), the presented challenges did not prevent them from engaging in their therapy and were not strong enough to cause unhealthy psychological distress.

Participant observation throughout the therapy did not raise any safety issues, neither physical nor psychological. No reports or observations were made of any unusual reactions, emotions or behaviours, apart from those, which would normally be expected in a psychotherapy setting. Physical safety was ensured by adhering to clear procedures of cleaning and handling art materials, which were explained to participants in their first therapy session.

Participants seemed to have generally responded well to the intervention and have engaged with the therapy process at all stages, despite some being especially difficult.

For the duration of the project, therapy seemed to have become an important and accepted component of participants' every day routine.

Although there seemed to have been a general acceptance of the therapy among group members, their responses suggest that at times they felt unsure of its purpose and their own progress. Doubts and uncertainty were present throughout the process of therapy and concerned not only the purpose of treatment and its effectiveness ("I doubted in the use of it for me", "I'm not sure what I'm getting out of it"), but also own ability to take part in the process in a meaningful way. One person reported in the final interview:

"I feel very vague about the intention and what we were supposed to make out of the therapy, what we were supposed to put into it, what we were supposed to get out of it ourselves. I'm still swimming around and not sure of it."

Although experience of uncertainty may just as well be an implication and indication of individual struggle with the therapy process, it is recommended that in future projects more attention is given to ensure that participants feel safe and more grounded in their treatment. Maximisation of participants' trust in therapy, provision of a stable and safe environment and being as clear as possible about the purpose and scope of therapy should at all times remain in focus of the therapist and the researcher(s).

4.4.6 Increase of clinical experience with the intervention

Establishing a safe, accepted by clients and therapists and as clear as possible intervention was a crucial part of the project. Gaining experience in putting it into practice and being able to observe any flaws was one of the major aims of the research.

In order to possibly replicate similar study in the future, the intervention needed to be standardised and clearly documented. Therefore, the project was preceded by a complex process of the development of a treatment manual (see also section 4.2.4.2). The therapist was informed about this process and had a chance to familiarise herself with the sections 1 and 2 of the manual in a written format, while sections 3 and 4 were described to her verbally and completed in writing once the course of therapy had started. This obvious limitation partially explains the reasons behind a few differences

between the planned and documented intervention and the intervention which was actually delivered. Any observed dissimilarities will be reported further in this section.

Generally, by the end of the project both the researcher and the therapist felt that their experience with the design and delivery as well as understanding of the intervention and its suitability for use with depressed adults increased significantly. The gained knowledge and skills could be utilised to guide any similar future projects. The whole experience allowed for several useful conclusions to be drawn and areas for improvement will now be highlighted. It is exceptionally important to acknowledge participants' invaluable contribution to the conclusions presented below.

4.4.6.1 Duration of therapy

Firstly, it became apparent that, while the brief model for therapy for depression could still be recommended, the duration of therapy in this project was not lengthy enough to ensure comfort for both the therapist and the participants. Initially twelve sessions were planned, which, due to time constraints and therapist's commitments, needed to be cut to just nine sessions of therapy. This necessity was reluctantly accepted by both the therapist and the researcher, who strived to offer full course of treatment in this accelerated timeframe. Within first few sessions it became clear that not all of the planned therapeutic aims may be met in the set time, which remained a main concern of the therapist throughout the project.

In their final interviews some of the participants shared that they would welcome an opportunity to be involved in the project for longer as they believed this would have been of a more benefit to them. (e.g.: "It could be helpful but over a longer period of time. Some kind of effect it would always have [but] if you take it over longer period of time, you would probably see more results.") One participant wondered whether the process of therapy would become less challenging with time: "I suppose if you're doing this for longer, get to know people better, it gets easier." The therapist and the researcher remained aware that for some participants the very brief course of therapy did not allow for a more in-depth engagement in the process.

With participants' safety in mind at all times, the therapist and the researcher decided that the introductory and closing stages of therapy may not be ignored and sufficient time was allowed for them, leaving not enough time for the main part of the therapeutic process, when normally the most significant problems are worked through. By the time the participants reached this most profound moment in their therapy, it needed to be slowly brought to an end to enable a safe and timely closure.

Phase 1 of this research revealed that the issue of time is crucial in the treatment of depression (see section 4.2.3.2.1 and further discussion in section 4.2.3.4.2) and it remained one of the main concerns during art therapy sessions. However, it needs to be highlighted that the obvious constraint had its advantages and possibly assisted in strengthening of participants' motivation to take part and remain in therapy. It was apparent to the researcher that the number of sessions and the implied commitment seemed immediately acceptable for all potential participants. Also, the short course of therapy seemed to increase participants' willingness to fully engage in the process from the very first session, although there may be various other reasons for that, as discussed in previous chapter (see section 4.3.2.1.2).

Brief art therapy for depression remains, thus, recommended. However, the number of sessions in future projects should potentially be increased to between 12 and 16. Such length of therapy is often mentioned in arts therapies studies (e.g. Jeong et al. 2005, Albornoz 2011, Chou and Lin 2012) and 16 sessions is a standard for a much acclaimed Interpersonal Therapy (IPT) for depression (IAPT NHS 2013; Klerman et al. 1994) and recently developed Dynamic Interpersonal Therapy (DIT) focused on targeting depression (Lemma et al. 2011) and possibly relevant to arts therapies. The proposed duration would allow for an extended middle part in therapy process and for a more in depth work to take place in a safely controlled but more generous timeframe.

4.4.6.2 Duration and structure of sessions

Remaining within the issue of time, the duration of a single session was set for one hour, which again proved slightly too short. The therapist and the researcher often felt that a more relaxed timeframe of sessions could potentially promote more openness and sharing between participants. While each session was divided into three equally long

parts, it is recommended that in future projects the art making and the final discussion times are extended and the sessions last for either 1.25 or 1.5 hours. It is not recommended that the sessions last for longer than 1.5 hour each.

In their final interviews the participants reported that the sessions generally seemed to have been either just right or slightly too short. One participant commented:

“Half an hour would maybe take the pressure off people. I did my art spontaneously, there was no beginning and end, so I could stop whenever, but for other participants time would maybe cause pressure.”

One person shared that she/he would not like the art making time to be extended (“I didn’t feel that I was rushed to finish”) as this seemed to be threatening and encouraging too much thinking and analysis (“I would struggle more to think about what to draw”). Interestingly, the perception of time in the sessions differed between participants and between the stages of therapy (e.g. “when we sat around talking, it felt longer”). One person shared that while the art making and discussion times seemed far too long in the first sessions, they gradually became not enough with the progress in therapy.

4.4.6.3 Number of sessions in a week

Delivering therapy in an intensive, twice weekly mode may remain recommended for future projects. As intended, such mode of therapy seemed to have promoted engagement in the process and, by defining a clear timeframe and promising a more foreseen finish, additionally made the commitment to therapy easier. In their final interviews some of the participants shared their appreciation for an intense course of therapy. One person mentioned that having to attend sessions twice weekly helped her/him to structure and give purpose to her/his week (“it kept me busy”). Generally, devoting more time in a week over a very specific period of time seemed to have offered meaning to the process and possibly helped to prioritise the therapy over other commitments in those few weeks.

4.4.6.4 Group rules

Although time was spend during the first therapy session to establish some general group rules together with the participants, many group members reported in their final interviews that they felt “uncertainty of what was acceptable and what wasn’t” during the course of therapy. One person described:

“I didn’t know what was ok, what wasn’t, I felt uncomfortable. Because it was portrayed as rules, and I am a very obedient person, I would follow it to a letter. The fact that it was rule bound, to me said ‘careful, caution’.”

Another participant described how the presence of rules affected her/his readiness to interact with others in the group:

“I didn’t think you could ask questions as it seemed intruding. Once I wanted to ask: ‘Why did you do that?’ because I was interested what the thought process was, but it seemed such an intrusion, they might have been uncomfortable, just respecting their privacy really.”

One person felt that the group rules prevented relaxation and possibly limited creativity: “The rules were important but the other side of it wasn’t really looked at – to enable us to relax and know what’s possible.” The same participant further explained why she/he was on occasions “desperate to say something”, but was often “holding back”: “Not really knowing what to do, not wanting to intrude on other people’s personal creation and possibly their thought and feeling behind it.”

Following the feedback from participants, it is advised that in future similar projects more attention is given and transparency is applied to the process of establishing ground rules and possibly participants are more actively involved. It seems important to ensure that the rules are accepted and thoroughly understood by every group member and that enough encouragement to discuss and amend them as and when needed is offered. Especially the rules regarding communication with other members of the group should be clearly stated and understanding confirmed by all, as any omission here may result in an even more pronounced, than usually in depression, inclination to withdraw from personal contact.

4.4.6.5 More direction

The treatment manual, following results from phase 1 (see section 4.2.4.2 and Appendix 11), advised that a directive approach is adopted to some extent and especially in the first stage of therapy – to relieve participants' anxieties and provide adequate structure to sessions. Although these intentions were communicated to the therapist, she was offered much freedom in facilitating therapy. In result of the therapist's preference a less directive approach was adopted in the project to enable participants to take decisions for themselves.

Although there seemed to have been an understanding of the therapist's intentions among group members ("I figured out that [therapist] doesn't want to push the group in one direction"), all participants felt that a more directive approach would have supported them better though the process of therapy and in fact enabled more meaningful interaction ("I'm inclined to think that being a bit more active on the therapist's part could have set things in motion.")

Some participants seemed to have recognised that more direction in therapy would have made the process easier for them ("it might have been helpful with a bit of direction rather than being on our own which could have been very stressful") and wished that some decisions were taken for them by the therapist:

"At times when nobody could make a decision on a theme, I did wish that the decision was taken for us rather than this waiting. Even if somebody came up with something, it took forever to move on from there. I think we would have welcomed that – 'just tell us or suggest'."

One person reported that she/he "was looking to the therapist for a lead", another shared that she/he "possibly expected the therapist to suggest themes" while another participant described how she/he awaited more encouragement from the therapist to explore certain themes:

"I felt that when an idea did come up that could be explored by everybody that wasn't threatening, I wish that the therapist would have taken that a little bit further, and people would have felt comfortable then coming in."

Similar idea was expressed by another person:

“Had the therapist taken the theme forward in any way, I would have picked up on it, I don’t know how other people would have responded, but I would have learned that it was ok to go there.”

One participant believed that a more directive approach would have helped the group members to connect, while their condition may have impaired natural interactions: “Because of the nature of depression you are very isolated from other people, that’s what happened in a group. That communication needed to be facilitated in some way.” Another person commented on an idea to engage in a group art making: “in order to do a group project, there has to be some kind of direction”. It seemed that participants expected the therapist to take a more clearly leading position and provide direction and grounding while challenging the group members and encouraging courage to explore difficult themes:

“Therapist was asking us what we thought of our own work and invited people to make comments and I know that some people must have felt uncomfortable with that but I expected it to be more like that.”

The researcher was often able to observe participants’ struggle with initiating ideas and taking decisions in therapy sessions. A more directive approach would have most likely relieved some of the tensions in the group. However, facilitating freedom to make decisions and empowering participants to take control seems crucial in therapy and especially in the treatment of depression. Therefore, it may be recommended that the treatment manual clearly states the expected amount of direction. It is possibly wise to suggest that a more directive approach is adopted in the beginning stages of therapy and in moments of especially difficult conflicts resurfacing. More guidance and leadership from therapist could also be recommended, including more verbal interventions in the time of discussion (e.g. paraphrasing, circular questions).

4.4.6.6 More structure / themes

The researcher’s and the therapist’s understanding of the use of themes in the treatment differed slightly. The therapist chose to offer substantial amount of freedom to participants in the first several sessions (with no given theme) and to engage them in

collective choice of themes starting from session five. The reasoning behind this decision was that themes might prove distressing and would therefore be better introduced once the group had gained a degree of confidence in being together and using art materials. In result, in the first four sessions of therapy the participants were simply asked to engage in art making without further clarifications or suggestions. Collective choice of theme in the beginning of every session started with session five and continued until the end of treatment. Participants were given freedom in the choice of theme and on occasions the process of making decision lasted long to enable all views to be heard and the theme to reflect the current need of the whole group.

In their final interviews most participants shared that they would have preferred more structure to the sessions (“if it was more structured, with a kind of theme”, “I found it difficult to think what to do”), especially in the beginning (“for it to be healthy for me, I would have needed this to be more structured from the get go”) and with themes relevant to them (“if it had been more structured with themes and if those were themes which were more relevant to me, then I would have gotten more out of it”). One person described how she/he welcomed the introduction of themes in the middle of therapy and explained how a certain theme helped her/him better engage in therapy process:

“In the first few sessions it felt like being back at school and getting free time in the craft corner, because we were just told ‘there are art materials, do what you want’, which in some ways was kind of fun, but I wasn’t feeling that I was getting much out of it. The one session when I found that I was getting something out of it was when we were given a theme and the theme was ‘confidence’ – ok, that’s something I can connect and work with and I thought I got more out of it.”

Another person admitted, on the contrary, that themes initially seemed more challenging than the given freedom to make art:

“I found some of the things hard, like themes. There were couple of them, when I started panicking. I had no clue what to do. When we didn’t have a theme, while I still didn’t know what to do, once I started doing things, it kind of happened.”

One participant also mentioned that although making decisions on what to paint/draw in the first few sessions was challenging, the difficulties were always eventually overcome:

“If [therapist] told us what to draw it would be easier. Thinking what to draw is sometimes very difficult. But we all have come up with something every time so there was no reason for panicking really.”

The above words may suggest that a sense of empowerment was achieved through making decisions.

Participants also commented on the process of choosing a theme by the group and one person felt that the decisions took long and she/he did not like “the slow pace” of the sessions:

“Not enough action, too much sitting about and waiting for somebody to react to some comments from [therapist]. Even if somebody came up with something, it took forever to move on from there.”

Another participant explained how the task of choosing a theme initially seemed quite overwhelming and that she/he would prefer the therapist to assist in the decision:

“I possibly expected the therapist to suggest themes, because when it is a group that hasn’t been together for a very long time, it’s asking quite a lot from participants to ask them to suggest themes. I certainly didn’t feel confident enough to suggest a theme, I wanted a theme, but I wasn’t able to say what I wanted to do. I think that therapist based on the knowledge that they have about the group, should be able to think that such theme would be appropriate and then as weeks go on and you get used to and feel more confident with things, you would be maybe able to suggest themes.”

Generally, participants seemed to have been accepting of the themes which had been eventually chosen. While one person shared that she/he would like to see themes more directly relating to depression, another participant mentioned that such themes would have been welcomed but possibly more difficult to share with others: “If it was something more personal, like depression stuff, I wouldn’t feel comfortable having people looking at it and interpreting it.”

In any future studies, it may be recommended that themes are introduced in the very first sessions of therapy and, while they are chosen by the group, the therapist assists more actively in making the decision, if the group struggles. As time in therapy progresses, participants may feel more confident in making decisions and may possibly

decide not to use themes (or this may be suggested by the therapist when feels appropriate).

4.4.6.7 Other suggestions

It was hoped that some kind of group work was tried at some point in therapy, which did not happen as the therapist felt that the group members were not ready for closer interaction (confirmed by participants' comments during discussion time at least twice). However, final interviews seemed to suggest that reluctance to engage in group work was true for some members of the group only ("I was quite glad that we didn't do artwork together. I was quite happy to do my own thing."), while others seemed to have waited for opportunities to try out working more directly with others ("Interaction would be better, to try it with the group of others where personal process goes."). One participant's response seemed to have explained how more direction from the therapist's side might have enabled group work: "In order to do a group project, there has to be some kind of direction. I didn't think we were at that stage because I don't think anybody would want to put themselves at that risk."

No clear conclusion may be drawn from this project regarding whether group work is recommended in art therapy for depression. There's no clarity as to whether it should arbitrarily be included in the treatment manual. However, the potential benefits of group work should not be marginalised and possibly utilised, if the therapist considers this safe for a particular group in a particular time.

Among other suggestions and comments from participants were several ideas, which could possibly be explored further in future projects involving art therapy for depression. While some of the ideas would clearly not be feasible as they would jeopardise the therapy process, it is still believed that they should be presented here briefly to allow the voice of the group members be heard.

One person shared that she/he would have liked to see more action in the sessions, including exploration of sculptural techniques or even elements of movement:

"Maybe I would have seen clay put in the middle of the table, stick your hands into it and make one sculpture out of it. Even though I think a lot, I'm basically a

doer. (...) All the participants who are really blocked, get them to move physically, see whether this would help unblock them.”

Personal introductions at the beginning of therapy were welcomed by at least one participant, while another admitted that she/he would have preferred to get to know other participants at her/his own pace:

“It’s the going round, talking about yourself, it’s really hard to do that. You’re so anxious about it that you can’t even remember anybody’s name or what they’ve said. I wonder if this was cut out and you could just meet people.”

Also, the fact that the therapist and the researcher were silently present at the working table during art making was considered uncomfortable by one participant (who, however, did not object to the therapist’s question whether this was acceptable):

“I personally found it difficult having you and [therapist] watching all the time. I was expecting you and [therapist] to move about more as I think this was decided. Nobody replied when you asked if we minded if you watched. I would have felt more comfortable if you weren’t there all the time.”

Asked whether they would recommend art therapy to other depression sufferers, the participants generally acknowledged that while it might be beneficial for depressed adults, the extent of the benefit depended largely on individual suitability to this particular type of treatment:

“Like most things, it would suit some people and not others. For the people that it’s suited, this would make very well and could develop into something really helpful - a process, when you can think about things in a slightly different way.”

Participants also noted that their limited knowledge of the treatment, uncertainty of the therapy effects on themselves and consideration for individual circumstances might prevent them from recommending art therapy. One person shared that recommendation would depend on whether therapy would explore feelings:

“I still don’t understand how people can benefit from it. If it’s not exploring, acknowledging inner feelings, I don’t see where it’s leading. But if it was accomplishing those kinds of things, yes, I would then recommend it.”

Another participant expressed need for more information: “I would consider but not sure enough to say ‘yes’. I think I might need to know more about how it would help, the mechanics of it to have the confidence to do it.”

Two of the participants believed that they would have felt more comfortable in an individual therapy and therefore it could have been more beneficial to them (“initially perhaps, as a stepping stone”). Participants’ struggles with being in a group as well as benefits of group therapy have been discussed earlier (see section 4.3.2.1.2). While participants’ preferences and suitability should be noted in any clinical intervention, it needs to be recognised that a group art therapy for depression seems to have implications potentially exceeding individual treatment. However, as sensed by one participant, an individual mode of therapy could possibly be a more beneficial “stepping stone” for participants, who need to regain confidence and balance required for engagement in group work and could potentially be considered as a subject of future research. Benefits of brief individual therapy sessions preceding group therapy were previously noted by Dokter (1996).

One participant’s comment seems to highlight and almost summarise many of the ideas already mentioned and additionally confirms that a safe and stable environment is the base, which enables a truly therapeutic process to take place:

“More openness from everybody, more of a lead from the therapist, more of a discussion, obviously always with understanding that you don’t intrude on other people’s difficulties. I personally would need to feel more comfortable and able to share my thoughts. I would need something to hold on to.”

4.4.6.8 Summary

A well utilised opportunity to increase clinical experience with the intervention presents a particular value of this project. Based on the knowledge gained the treatment manual may be corrected and enhanced with ideas more acceptable for future participants and potentially more relevant to depression. It is recommended that any research drawing on this pilot considers the points raised in the assessment of feasibility as a whole and in the section on the intervention in particular. Key recommendations for amendments to the treatment manual will be summarised in section 4.4.8 .

4.4.7 Estimation of a treatment effect

Regrettably, inability to include a control group in the project, makes any estimation of an effect size of the treatment impossible. While it can be learnt that statistically significant improvement in depression levels was observed in a single group comparison of initial and final/ follow-up conditions, no comments on the size of this effect may be made. In addition, it needs to be recognised that attempts to estimate an effect size are not always justified and in case of the project with a limited sample size it is likely that variability in any effect sizes obtained would be so large as to be unreliable. Such unstable estimates would potentially lose clinical meaningfulness. Therefore, while a missed opportunity to obtain a reliable effect size estimation is recognised, an aim to provide a comprehensive evaluation of the treatment and an objective assessment of feasibility has been retained, hopefully making this project clinically meaningful despite limitations.

4.4.8 Summary: Recommendations for further studies

Assessment of feasibility of a potential larger study was an important aim of this project and presented the researcher with many challenges additional and separate from the main body of this research. An objective and critical consideration of the circumstances under which phase 2 was developed and conducted required a scientific approach with a strong clinical emphasis. Feasibility was assessed based on observations made by the researcher, comments received from the therapist and participants' reflections collected in final interviews. Recommendations for corrections to the study protocol and the treatment manual were previously discussed in details and will now be summarised.

Although this project included a small sample, evaluation of recruitment procedures was positive overall with areas for improvement indicated. Unusual public interest in this research and readiness of potential participants and their relatives to contact the researcher via email are promising for further studies. A variety of channels used for distributing information about the project (community settings, health centres, peer support groups, charity organisations and online) and visual advertisement seemed to have generated enough interest among the public. However, a single researcher could

reach only a fraction of potential settings and therefore for a larger study, more researchers / research assistants would need to be engaged. In addition, more diversity of communication channels with the research team is recommended (e.g. telephone, drop-ins) and flexibility will arranging times/dates for interviews would be beneficial. Recruitment of 30 suitable participants seems likely in 6-8 weeks provided the improvements are in place.

Excellent retention rates in the project also constitute a good predictor for similar research in the future. Completion rate of 100% and attendance rate of 87% suggest that brief group art therapy was accepted by participants as a treatment option and attractive enough for them to remain committed until the very end of the therapy and the research.

This study included adults experiencing mild to moderate depression and diagnostic tools (PHQ-9 and researcher's experience of psychological assessment under psychiatrist's supervision) proved appropriate for identification of suitable candidates. However, due to a relatively wide range of severity of depression present in the group and its implications for therapeutic process (further discussed in section 4.4.3), it is recommended that future studies focus either on mild or moderate depression. Such practice seems particularly important in the context of brief therapy, where potential similarities in functioning of individual group members may promote faster consolidation of group aims and focus therapy process on area of most significance.

The presented pilot project was in its nature limited in resources which led to necessary corrections to initial ideas (see section 3.4.2). Should similar study be undertaken on a larger scale, certain resources would need to be put in place, including appropriate time allocation for obtaining necessary approvals from the NHS and development of a treatment manual. Involvement of a larger research team, including research assistant(s), also seems necessary, especially in recruitment stage and possibly when interviews are conducted.

Capacity and willingness of the identified setting to offer spaces suitable for facilitating therapy and interviews has been assessed positively and is promising a likely collaboration in future studies, provided that appropriate approvals are obtained. This project did not require specialist equipment and suitable art materials for similar

projects, even on a larger scale, would be easily available and not expensive. Apart from therapeutic intervention, the tools used in this study included three questionnaires, generally accepted by participants as not too overwhelming to complete on three occasions, and semi-structured interviews, which were similarly accepted, but could be improved to ensure that functional assessment in three areas (personal, social, occupational) is included.

The intervention offered in this project was considered safe and accepted by the participants, who, despite challenges, continued with their therapy until completion. Physical safety should remain a priority in any following studies, as well as emotional safety which may be achieved by providing a stable environment with clear ground rules, accepted and understandable for all. Hope and trust in therapy should also be maintained.

Most importantly, this project allowed for an increase of clinical experience with the particular intervention and a number of conclusions may be drawn from the process. Firstly, while brief therapy intervention remains a recommendation for future projects, it is advised that the duration of treatment is longer than in the current project (possibly 12 or 16 sessions) to allow more comfort to both therapist and participants and enable more meaningful engagement in the core middle sessions of therapy. Intensity of twice a week sessions seemed to have benefited the current study and remains advisable. However, length of individual sessions should possibly be extended to 1.25 or 1.5 hrs to relieve likely tension related to time pressure.

A significant learning from the current project concerns ground rules in therapy and the importance of ensuring that they are developed with participation of group members, accepted and understood by all. Moreover, a more directive approach and more leadership from therapist is recommended, especially in the beginning stages of the therapy. The potential need for more direction highlighted by this study corresponds with another recommendation of more structure in early sessions of therapy. Structure here refers to themes used as guides for art making. The themes (potentially chosen by the group or suggested by therapist if decision making is difficult) may be best introduced in the first sessions and possibly withdrawn at later stages of therapy, depending on the need of particular group. Finally, group work understood as creating one piece of art by the whole group, remains a possibility to be explored in future

projects, although it was not attempted in the current study. Responses from some of the participants in this study suggests that individual therapy may possibly offer benefits to those individuals, who find group work especially difficult and may serve the purpose of initial introduction to art therapy before moving to more challenging group therapy. This idea may possibly be further explored.

In this project estimation of a treatment effect size was not possible, but remains a recommendation for future studies.

5. Core discussion

5.1 Introduction

Following the presentation of individual findings and initial discussion, this chapter aims to offer an even more in-depth understanding of the very core of this project and reveal further meanings. While an integration of data derived from a variety of sources has been constantly in the focus of the previous sections, the current chapter hopes to take the idea of integration further by extracting an essence from all findings. Due to the methodological complexity of this project, individual findings seemed to be appropriately discussed as they unfolded and thus, elements of discussion were weaved in throughout the presentation of findings. This chapter should not be seen as a continuation of this process, but rather as an attempt to identify more general and hopefully core points for discussion, coming from the project as a whole.

In order to offer an essence of this research and to ensure that the picture of arts therapies practice with depression is as complete as possible giving the modest scale of the project, further methodological procedures were considered and the final discussion will be preceded with a brief description of these additional analyses undertaken.

5.2 Identifying the Core

It could be observed throughout the report on this project how certain themes were recurrent in findings originating from a very diverse pool of data. Ideas which initially emerged from one source of data, were often reappearing in subsequent analyses and could be observed from multiple perspectives, which is believed to have added a rather three dimensional quality to the findings. However, within the richness of results, diverse aspects of similar concepts were often uncovered at very different points in the analysis and could not have been properly integrated without violating the clarity of presentation. It seems important, however, to identify and discuss those recurring concepts which bring special meaning to the project.

In order to assess the importance of certain ideas in relation to the whole project, all findings were scanned for multiple occurrences of similar concepts. Once a recurring idea was identified, a note was taken of every dataset, in which it appeared. In effect, a matrix of the most significant concepts (22 in total) and their sources was created. Subsequently, the concepts were weighted based solely on the frequency with which they appeared in the project. The figure below (Figure 34) gathers those concepts with font size indicating their weight in the overall findings. It is acknowledged that number of occurrences may be too simplistic a way of assessing overall value, especially in the light of limitations of this project. Therefore further presentation will begin with the most often recurring ideas moving to those which appeared in at least two sets of findings, until all concepts core to this research are discussed.



Figure 34: Concepts core to the project identified in findings.

Finally, whenever sources of findings are mentioned, they are followed by a number indicating the dataset, from which they originated. The coding for these was offered at the very beginning of this thesis, when the design and the components of the study were described (please refer to Figure 3 in section 3.2.2).

5.3 Core concepts

5.3.1 Time

Time seemed important in the context of arts therapies practice with depression from the very beginning of this project, while comments on the recommended length of therapy were easily identifiable in relevant literature, e.g. Gold et al. (2009: 193) report on music therapy with psychiatric patients: “Slight improvements can be seen with a few therapy sessions, but longer courses or more frequent sessions are needed to achieve more substantial benefits”.

Arts therapists, who took part in the survey (2) mentioned similarly that although they are often required to provide brief therapy, a longer time for treatment was preferable in order to address complex issues in depression. Not only length of therapy but also duration of depression were reported as factors influencing recovery. It was mentioned that treating depression in its beginning stage was more likely to bring positive effects. Therapists who work primarily with depression (3) offered an even further insight into the meaning of time in therapy. They reported using tools and interventions, which often concern the issue of time, like genograms or lifelines, and hoped that addressing time in treatment might bring realisation that depression was not eternal and could be treated.

The concept of time reappeared in phase 2 of this project, when it seemed apparent that follow-up interviews with members of art therapy group (6) revealed meanings and insights not available immediately after the treatment. Time seemed to have offered opportunities for experiences to consolidate and understanding to emerge. Moreover, increase of anxiety in some participants (4) and inconclusive results as to therapy’s impact on anxiety in general brought an assumption that a lengthier treatment could potentially offer more time for anxieties to dissolve as more confidence is gained and readiness to share develops within the group.

Time found its place again in the findings emerging from observation (5) (as therapy felt unfinished) and in the result of arts-based reflection (7), when the need to act quickly was felt by the therapist during the creation of an “essence” image, almost resembling the nature of a very brief therapy offered to participants.

5.3.2 Reconnecting

The concept named here as reconnecting appeared on numerous occasions throughout the project under other labels such as: social isolation, withdrawal, relationships or need for connection. The two opposing forces of tendency to withdraw and deeply internalised wish for meaningful connections was a recurrent theme in findings from all areas of inquiry. The notion was often referred to as a paradox of depression.

Reconnecting to self, others and to what brings joy was considered one of the aims in the treatment of depression sufferers by arts therapists who responded to the main survey (2). It was also recognised that the commonness of depressive symptoms often helps people experiencing mental ill-health relate to each other, while depression quite paradoxically “binds them together”. Therapists who work with the condition specifically (3) highlighted the need of depression sufferers to both isolate from and relate to others. This tension between avoidance and desire for engagement easily leads to “stuckness”. The therapy was recognised as offering potential for breaking the vicious cycle by promoting experience of openness and sharing induced through creativity.

Participants in the art therapy group (6) confirmed that they recognised own tendency to withdraw from contacts with other people and avoid sharing which additionally causes a feeling of guilt and not meeting expectations of friends and family. The subject of relationships seemed to have been especially significant to the group members and evoked strong emotions during interviews. Desire to be closer to others and to form meaningful and satisfying relationships contrasted with inability to sustain or initiate such connections seemed to have indicated a particularly challenging and painful aspect of depression. Difficulties with trusting and expressing emotions were recognised as obstacles on the way to meaningful connections. In relation to what has just been said, it was not surprising that being in a therapy group had been an especially challenging aspect of the treatment for the participants. The theme had been widely explored in final interviews, when the group members shared that they would have liked more connectedness with others during therapy. It seems important that the expressed desire concerned meaningful communication and not any type of contact. Ambivalence between the need to feel connected and the anxiety which often prevented communication was apparent and often led to avoidance. Obstacles to forming

connections within the group were related mainly to the difficulties with sharing, but also to consideration of feelings of other participants and feeling under pressure while in the group. However, despite difficulties, meaningful connections were made on occasions and these seemed to have left memorable impressions on the participants, while connections and meaningful verbal and non-verbal exchanges were most often identified as especially significant moments in therapy.

The themes of “close” and “sharing” originating from observation (5) seem to relate to and extend the discussed concept of reconnecting. More and less successful attempts to share were observed throughout the duration of therapy. It seemed to have been a process from particular struggles to making effort and to eventually share in a meaningful way. However, while sharing increased the feeling of closeness to others, it became difficult to withstand and tempting to withdraw again. Arts-based reflection (7) brought the themes of “connecting” and “separate” and seemed to highlight the tension between these concepts. An ability to tolerate closeness formed within the group may be one of the biggest aims and challenges in therapy.

5.3.3 Trapped

The concept of being “trapped” seems to have several layers, not easy to describe. Feelings related to it appeared early in the findings, when arts therapists (2) commented on main features of depression, like going “inside oneself” and “turning inwards” and further (3) referred to the condition as a “stuck place”.

Similar set of feelings and tendencies was mentioned by the members of art therapy group (6), who admitted to “shutting themselves from the world”, “wanting to hide away” and to be on their own, while feeling the need to leave these metaphorical cocoons and being unable to.

In the therapy itself, “trapped” seems to also relate to the creative process, while many of participants’ responses evoked a sense of feeling “stuck” and often not being able to create spontaneously. It also explains some of the aspects of the previously described concept of reconnecting, as the group members, while willing to engage in meaningful communication, felt disempowered and often unable to do so. Similarly, exploration of

more challenging themes was both desired and extremely difficult to initiate (which will be explored further).

Observation (5) brought further understanding and confirmation of the importance of this concept. An increase of sharing and closeness within the group caused a tendency to withdraw again as an effect of feeling “trapped”. The tension between the desire to be close and to “turn inwards” seems to lead to avoidance and impasse. As mentioned by one of the therapists (3), helping clients to overcome this overwhelming “stuckness” may need to become one of the crucial aims in the treatment of depression.

Further ideas relating to the concept were uncovered through arts-based reflection (7), when walls and boundaries seemed to control and enclose the energy which strives to escape. Again, the tension could be felt between the “in” and “out” when this energy was controlled while slowly getting ready to move “outside” in the therapy process.

5.3.4 Anxiety

Anxiety, the most common co-morbidity of depression (Hammen & Watkins 2007), was, not surprisingly, accompanying participants throughout their therapy and was recognised by arts therapists in phase 1. Findings on the role of anxiety in depression have remained inconclusive in both phases of this project and the concept seems to hold a degree of ambivalence.

Arts therapists (2, 3) mentioned anxiety as one of the core underlying problems in depression and acknowledged the need to address it in treatment. One response suggested that anxiety could be reduced through group work which did not seem to correspond to later findings.

For the members of the art therapy group (6) anxiety seemed to have been a much recognised feeling throughout their lives. In this project, it found its place in all stages of therapy and seemed to serve various roles. Anxiety firstly appeared before the therapy, when participants shared their expectations, and was generally related to one of the two areas, or both: being in a group and revealing painful memories or knowledge. After the therapy some participants shared a feeling of increased anxiety as one of the outcomes. Scores on one of the questionnaires (4) confirmed that while anxiety levels

decreased for three participants, they rose for two others (and, although fell in the follow-up, still remained higher than before the therapy). Possible explanations were discussed in section 4.3.2.3.2.

In observation (5) anxiety seemed to have been most explicitly present in the first sessions, when the sensing of “something to emerge” caused tension in the group. Once the disabling anxiety had been relieved following expression of emotions, more challenging themes could be explored and in the final sessions it seemed that anxiety remained reduced.

There are a number of inconsistencies here. Firstly, arts therapist’s suggestion that group work relieves anxiety is in opposition to what was reported by the participants. Secondly, increase of anxiety reported by the group members at the end of therapy did not seem to be detected in observation. Although the author acknowledges subjectivity of this point, she suspects that the key to understanding some of these inconsistencies lies in the subject of anxiety as recognised by participants. It seems that the group members feared (and awaited) the exposure of insights, as possibly carrying painful realisations. Once self-knowledge and awareness of others grew and insights emerged in the second part of therapy, they could have possibly brought uncomfortable feelings and anxiety would be an understandable reaction to these. Further research in this area is highly recommended (see section 6.3).

5.3.5 Challenge

Challenges were present throughout the exploration of findings. Initially, arts therapists (2) admitted that working with depression was challenging to them as well as to clients, who often struggle with acceptance of their condition. More specific difficulties mentioned (3) included low responsiveness of clients in therapy but also challenges around the provision of psychotherapeutic treatment for depression, which does not seem to be adequately supported.

Participants in art therapy group (6) admitted to have experienced numerous challenges during the process of treatment, with two areas presenting most problems, i.e. working in a group setting and self-expression. Both themes became the core concepts in this

discussion: first one explored already under the name of “reconnecting” and the later to follow.

Difficulties experienced by the group could have been more closely observed (5) from the point when participants decided to make effort to engage until the very end of therapy. While challenges continued to be experienced throughout the therapy, the subject of these difficulties seemed to have changed in the process. Initially the sole engagement in art making and sharing with the group was considered most demanding, but once the group progressed towards new insights the subject of challenge seemed to have shifted to the difficulties around dealing with uncomfortable themes and observations about self.

5.3.6 Underneath

One of the most complex concepts emerging from this project must be the quite enigmatic idea of “underneath”. It encompasses the sensing of “something” not being fully uncovered but immensely important, which could be found in most of the findings.

In the very first set of findings (2), an arts therapist believed that rather than addressing depression directly, therapeutic work may (or should?) be done with symptoms around the condition in hope that focusing on related issues would eventually lead to decrease of depression itself. While this approach may be reasonable, it leaves a feeling that depression may be better left unspoken of.

Further stages of the project revealed much about the tendency of depression to remain “underneath”, not easily addressed directly. Participants in art therapy group (6) later shared that the subject of depression remained “an elephant in the room” throughout the therapy. They admitted that bringing the most painful and distressing themes into the group discussion or artwork was difficult and often impossible, but also shared the willingness to explore those uncomfortable subjects. Depression itself seemed to have been covered by layers of avoidance, tension and other issues. In their final interviews the group members seemed to have been ready to explore the very core of depression in their treatment and wishing this was done in therapy. However, perhaps issues central to depression needed to be uncovered first to reveal what really needs to be addressed?

Observation (5) brought further insights into the role of “underneath” in the therapy process. While tendency of the group to “hide” and tension was apparent in the first stage of therapy, “layers” and waiting for “something to emerge” seemed to have caused these. Once it became clear that revealing of issues deeply hidden is inevitable, the tension was relieved and progress in therapy could have begun.

Similar concepts appeared throughout the arts-based reflection (7), where tension seemed to be felt between the world “underneath” and the world “outside”. Layers were both covering and revealing and “life underneath” could have been sensed – it was “growing under” and ready to emerge through therapy.

5.3.7 Motivation

The importance of motivation in successful treatment of depression and the lack of it and clients’ frequent inability to engage were mentioned by the therapists (2, 3). Thus, using encouragement as a tool to facilitate motivation was considered crucial, especially in the beginning stages of therapy.

Contradictory to arts therapists’ experiences, motivation to take part in the project and the therapy seemed to have been unexpectedly high among the group members (5, 6). It may be quite safely assumed that autonomous motivation, which was required to take part in the project in the first place, enhanced the feeling of achievement , which participants experienced (further commented on) and possibly empowered the group to explore more challenging territories.

5.3.8 Hope

Considering that depression involves lack of hope for the future, facilitation of trust in therapy and regaining of the sense of hope was seen as important by the therapists (2). Creativity was believed to support the “positive generation of hopes and solutions”. Therapists acknowledged (3) that the clients often did not trust in effects of therapy, as they simply did not believe that change was possible. Starting therapy with referring to the time or place where engagement used to be possible seems to be a sensible solution to strengthening hope.

Participants in art therapy group (6) also mentioned that they would have liked the therapy to help them relax and “know what’s possible”. Expression of a similar idea was observed (5), when the need for relaxation was shared by members of the group. It seems that the participants sensed that the tension they felt needed to be relieved before a more meaningful work may progress.

5.3.9 Acceptance

In the very first findings (2) the notion that acceptance of being depressed is needed for a meaningful engagement in therapy was recognised by the therapists. This is not obvious, as clients often struggle with this and may need time to be able to accept depression. Difficulties with defining the problem often lead to further inability to accept support from others and therapists believe (3) that arts therapies, especially in a group setting, may offer opportunities for exploring this reluctance to open up and express the need for help. Experimenting with own creativity in a safe group setting may support sharing and acceptance of others in recovery process.

The theme was very present among the participants of the art therapy group (6), where, for example, a difficulty with acceptance of depression and referral to the psychiatrist was expressed. At the end of therapy one participant in particular shared the feeling of acceptance growing and considered that fact of being able to recognise own depression and that it requires support one of the main outcomes of the therapy.

In observation (5) it seemed significant that the theme was present throughout the therapy with varying intensity, from the lack of acceptance in the first few sessions to emerging acceptance of challenges and newly made discoveries about self and others in the sessions towards the end of therapy.

5.3.10 Self-expression

Quite an obvious finding from the beginning of this project (2) was that arts therapists valued self-expression in the therapy and considered opportunities to explore creativity unique to arts therapies and especially beneficial to clients suffering from depression, who may find it difficult to achieve “emotional expression for their experience”. Self-

expression was considered crucial for self understanding and both verbal communication and creative techniques (3) were believed to facilitate the process.

In the art therapy group (6) this concept was further explored while participants shared difficulties with expressing emotions and considered this a main challenge of therapy. It became apparent that, although there is a common acceptance that creativity may be beneficial and a main tool in arts therapies, in working with depression in particular self-expression may present increased difficulties to clients. This challenge relates to the previously described concept of “trapped” when participants felt disempowered to create and “translate thoughts of feelings onto paper”.

Observation (5) brought the concept of “freedom / letting go” at the very beginning of therapy, when it seemed that the group was willing to explore spontaneity, before it became obvious that this proved too difficult to do. However, in the second half of the treatment the group’s ability to use self-expression was growing. It seems apparent that increase of confidence to express emotions preceded the most noticeable progress in therapy and a conclusion may be quite safely risked that self-expression eventually enabled more meaningful themes to be explored.

5.3.11 Sense of self

As mentioned above, self-expression is hoped to lead to an increased understanding of self. Arts therapists (2, 3) shared that they considered the weakened sense of self to be particularly relevant to depression and believed that therapy might facilitate greater understanding and reconnection to self, as well as self belief.

In the art therapy group (6) an increased awareness of self was among the outcomes most often mentioned by the participants and seemed to have been especially valued. Group members shared that the therapy had helped them to learn more about themselves and rediscover aspects of self, which previously remained forgotten. Moments in which such discoveries took place were considered especially memorable. New insights included ability to express oneself and ability to connect to certain themes.

A growing awareness of self, of own traits, skills and feelings, could also be observed (5) in the therapy process. The theme of “insight” seems to refer to this increasing

understanding of self. Importantly, the group very clearly noticed the difference between the true awareness of self and egocentrism or unhelpful self-consciousness and recognised that self awareness is essential for understanding of other people and what happened in the environment.

5.3.12 Awareness of others

Therapeutic aims for the art therapy group in this project included an increase of awareness of others as a counterbalance to unhealthy self-consciousness, identified as one of the underlying problems in the group.

The theme was given a special significance by the participants (6), who considered the increased awareness of others an important outcome of their therapy, especially in relation to the recognition shared in initial interviews that directing though process on other people was helpful. Development of awareness also meant a growing appreciation of others and their problems. Moments in therapy when an important verbal/non-verbal exchange between the participants or a meaningful connection was made were among the most memorable. Participants shared how their attention and interest in other members of the group developed throughout the therapy and how this helped them move from their isolation towards sharing.

The concept was very present in observation (5), where a readiness to open for others and a growing awareness of others and of the outside (e.g. landscapes, the past) could be noticed towards the end of therapy, presumably as a result of gained insights. Arts-based reflection (7) offered related themes of “towards”, “stepping out”, “reaching out”, which seem to relate to the growing readiness to move from isolation to connection with others.

5.3.13 Insight

Expectation that the therapy would bring insight was expressed by the members of the group (6) before their treatment. They later identified some of the gained insights (into other people, into feelings, into the meaning of therapy) as outcomes in the therapy. It

also seemed that the most memorable moments identified by the participants were related to these new discoveries about self or others.

An idea of 'growth' seems to be closely linked to new emergent insights. Growth, depicted symbolically as plants and also present in the metaphor of a journey, could be observed (5) as part of the therapy process. It was also apparent in arts-based reflection (7), both in the outcome "essence" image and in the process of creation, while elements of the image seemed to be growing from underneath and reaching out.

5.3.14 Balance

The need for balance was expressed by the members of the group (6) before the therapy. It seemed to be a significant theme in the interviews, as participants were highlighting their usual struggles to "avoid highs and lows" and one person shared that not to be depressed is equal to feeling in balance. This need seemed to have been revealed and observed (5) in the therapy process, among other needs expressed at the beginning of therapy. It also seemed to have been related to the theme of 'darkness and light / ambivalence', which metaphorically represented participants' struggles not to swing towards one of these ideas. Balance appeared again in arts-based reflection (7), when certain elements in the image were 'controlled' and strived to balance each other.

As a suggestion for further discussion, it may possibly be argued that need for balance is in fact the need for authenticity and for seeing the world and oneself as it is – real and not affected by depression.

5.3.15 Meaning

Search for meaning appeared to have been intertwined among all stages of this research. Initially, the concept was found in art therapists' responses (2) which highlighted that therapy had the potential to unfold new meanings in front of clients through their engagement in creative processes. Other responses (3) mentioned clients' inability to engage in meaningful activities. Therapists also noticed the feelings of life

being meaningless, as well as a sense of emptiness and endlessness common in depression and the need for meaning seemed apparent.

Loss of meaning could be sensed among the group members (6), who admitted to have lost a sense of direction, compared their state to a fog and shared fears of what the future hold, while the meaning was clearly missing from their lives. A wish to be purposeful, “to have a place and some meaning” was also directly expressed.

It seems especially significant and promising that by the end of their treatment participants were able to identify meaningful moments in therapy and indicate what meaning the whole process hold for them, which included: becoming more spontaneous and creative, acceptance of own feelings, opportunities to “get things out”, increased attention towards others and an increased readiness to share.

5.3.16 Other concepts

Besides the concepts described above, other ideas, although less often mentioned in findings, seemed to have added no less value to the inquiry. These will now be brought into the discussion to complete the picture of arts therapies practice with depression, as emerging from this project.

a) Anger

Arts therapists (2) reported on anger as noticeable in their practice with depression and some members of the group (6) admitted to the feeling. They recognised that they tended to direct their anger and frustration internally and that it affected them both physically and emotionally. Frustration was also among the feelings reported at the end of treatment, as a response to partially unmet expectations of therapy.

b) Guilt

The concept of guilt seems to be commonly linked to depression and was quite unsurprisingly mentioned by arts therapists (2), who recognised the feeling of guilt and not being worth the attention of others among their clients. Similar feeling could have been sensed in observation of the group process (5) and in participants comments (6) on their perceived dispositions.

c) Loss

Arts therapists (2) noticed the connection between depression and loss or grief and the members of the group (6) shared their experiences of bereavements and losses before their therapy. Those bereavements did not necessarily mean losing a close person and were also identified as losses of responsibility and major life changes.

d) Thoughts

The cognitive aspect of depression was present in the findings. Arts therapists (2) acknowledged the impact of beliefs about self and the world on depression and reported that their clients tend to see the world as unwelcoming and dangerous, life as being meaningless and themselves as unable to manage its challenges. The members of the art therapy group (6) also recognised cognitive processes to have influence on their mood and shared that they often preferred to distract themselves from unhelpful thoughts. One participant identified diverting attention from self onto the outside world as helpful in breaking the cycle of crowded thoughts (Desseilles et al. 2012).

e) Complexity

Complexity of depression was an apparent theme throughout the findings. Firstly, arts therapists (3) recognised that determining the cause and effect in this condition is not always possible and a large set of underlying problems was identified. Secondly, complexity of depression could have been clearly observed (5) while it unfolded in the therapy process and revealed not only a richness of layers but also a strong dose of ambivalence and the presence of light and darkness simultaneously. Similarly, “layers”, “mixture” and ambivalence of “in and out” emerged from arts-based reflection (7).

f) Co-morbidity

Close relation of depression to other conditions was commonly acknowledged by the arts therapists (2, 3). The practitioners mentioned that depression is often dominant but not a primary diagnosis and listed many of its co-morbidities, among the most common including: general mental health problems, PTSD, personality disorder, anxiety and self-harm. The fact that people suffering from depression do not form a homogeneous group has implication for clinical practice, especially in case of group work, where

offering best person-centred treatment is challenging due to various presentations of depression.

g) Holistic approach

In line with general notion in available literature (see section 2.2.1) and among practitioners known to the author, a holistic approach to depression seems also convincing for arts therapists (2), who, quite unsurprisingly and especially relevant to dance movement therapy practice, highlight the need to engage clients on the mind as well as the body level. Some therapists also agree that medication may be helpful, in addition to arts therapy, especially at the beginning of the treatment. Complexity of depression may demand a holistic approach in the therapy process as well, where the whole person and their wellbeing rather than singular symptoms are in focus. To address the complex presentation of depression most therapists (3) tend to integrate various therapeutic approaches, as seems most suitable for particular clients.

5.4 Final discussion

The concepts core to this project do not claim to offer an exclusive list of factors core to the treatment of depression through the use of arts therapies. Nonetheless, they have helped extract the meaning of this study and could hopefully inspire further investigations into how arts therapies may facilitate healing in the case of depression (see section 6.4).

The detailed findings and additional extraction of the core concepts seem to indicate similarities and differences between arts therapies and some forms of verbal psychotherapy and clearly demonstrate the nature of psychotherapeutic process as opposed to the process of participating in arts activities. Many of the identified concepts could potentially be relevant to any psychotherapy based on psychodynamic and humanistic principles. However, the process of the themes emerging in therapy seems to be unique to arts therapies, in which opportunities for self-expression facilitate psychological change. In case of this particular project artistic expression has clearly led to progress in the art therapy group. Similarly, exploration of creativity and engagement

in artistic process has been identified by arts therapists as central, potentially very powerful and undoubtedly unique feature of arts therapies.

Further discussion will once again delve into the core of this project, this time linking it to the knowledge available from other studies. The discussion by no means aims to be conclusive, but instead hopes to raise questions and ideas for further exploration.

The concept of time, identified as especially central in this project, is not unknown in psychotherapy literature. In fact, it is central to many interventions and continues to provoke controversies, especially among psychoanalytically oriented therapists. However, brief forms of psychotherapy prove to be effective if facilitated by experienced and disciplined therapist. Mann (1980) argues that 12 sessions of therapy is “the minimal time required for a series of dynamic events to develop, flourish and be available for discussion, examination and resolution” (Mann 1980: 15). The same author also notices that the “time and the unconscious meaning of time are the constant accompaniments of the now” (Mann 1980: 5) and thus are also relevant to humanistic paradigms, which postulate therapeutic work in the “here and now”. Demands of brief psychotherapy require that therapists are modest and realistic in their practice and that they

“adopt an active stance which conveys the confidence, the good will and the promise that will engender spontaneous belief in a successful outcome, without creating an impression of magical authority or of solutions imposed from above” (Mander 2006: 84)

In addition to pressures on the therapist, brief mode of therapy itself may impact clients' attitude. While there is no place in the therapy for nurturing, dependence and regression (Mander 2006: 91), clients' motivation and readiness to take responsibility for their treatment is crucial (McNiff 1981: 11). Autonomous motivation, quite unintentionally encouraged by recruitment procedures, proved to have been helpful in this project, as participants seemed ready to make effort and face challenges in an intense but brief therapy.

Donald Winnicott, whose work is much acclaimed by arts therapists, speaks about time as a necessary factor in shaping the meaning of repetitive losses which must be endured throughout life (Winnicott 1988). Thus, the concept seems to be particularly relevant in

addressing depression, often linked to bereavements. Mazza & Price (1985) demonstrate in their study how the focus on time supported the meaning of the integrative arts therapy they offered.

Further in the field of arts therapies, Dokter (1996) acknowledges the need for dependency to be actively discouraged in a brief dramatherapy but simultaneously recognises that clients suffering from depression often “combine the extreme fear of and extreme wish for dependency” (Dokter 1996: 193). This seems to be only one example of ambivalence in depression, among the fear and need for reconnection and the striving to be close to others but alone. The concept of a vicious cycle is often used as a metaphor for the complexity and paradoxes of depression (e.g. Moorey 2010) and has been also noted by arts therapists who participated in the survey (“the repeatedness and hopelessness of depression”).

The theme of meaningful connections and their ambivalence in depression has been raised on several occasions throughout this project (e.g. section 4.3.2.2.6, section 5.3.2) and therefore will not be elaborated on further. However, it possibly remains important to notice that “artistic action is concerned with deepening relationships [and] this dimension of art has far-reaching implications for psychotherapy” (McNiff 1981: 42) and continues to be one of the most powerful tools in arts therapies.

Among arts therapists there seems to be, understandably, a common agreement that engagement in the creative process has an immense healing power. In the case of depression in particular, where clients tend to turn inwards and avoid self-expression, creativity may be impaired (as also indicated by one of the participants in the art therapy group offered in this project), which has far reaching implications for arts therapies. It seems crucial that enabling of creative process to take place is facilitated before any further work may be attempted. Reflecting on own dramatherapist’s experience Grainger (1991) explains:

“Instead of experimenting with alternative ways of construing an expanding range of experiences, depressed people avoid anxiety by construing their perceptual field to exclude events that are not easily contained within their existing range of constructs.” (Grainger 1991: 13)

Experience from this project seems to suggest that tension and conflicts, although theoretically generate energy, in fact prevent self-expression and a degree of relaxation seems to be needed for creativity to flourish. Contradictory to some beliefs, creativity seems to be a sign of wellbeing (Spaniol 2001) and much of the time in arts therapy process may need to be spent on facilitating a safe environment and release of tension in order to enable self-expression. A basic provision of hope for participants and of trust in the therapy may eventually trigger creative ideas. Lloyd et al. (2007) report on the arts therapeutic programme, where “although participants struggled to engage in their art consistently, the motivation to persevere was present because of their hope of recovery or what possibilities lay ahead” (Lloyd et al. 2007: 211).

Aldridge et al. (1990) propose the use of simple repetitive techniques at the beginning of therapy to facilitate relaxation and hope. In this project it seemed apparent that the members of the art therapy group expressed the wish for more structure especially in the first therapy sessions and seemed to have needed clear rules and direction. However, the fact that they have successfully dealt with challenges, including tension and anxiety, could have eventually led to the progress observed and has clearly evoked the feeling of achievement at the end of therapy.

Balancing between just enough tension (needed for creative energy to emerge) and relaxation (allowing for release of this energy) in the therapy process seems to be a challenging task for an arts therapist. However, engagement in artistic expression has the potential to emotionally rebalance the psyche. McNiff (1981) notices that “when a person is suffering from severe emotional disintegration, the arts can be helpful in gradually establishing perceptual order and clarity” (McNiff 1981: 36). In their very recently published work on art in therapy, so adequately timed with the end of this project, De Botton & Armstrong (2013) explain the power of arts in re-establishing balance: “Art can put us in touch with concentrated doses of our missing dispositions, and thereby restore a measure of equilibrium to our listing inner selves” (De Botton & Armstrong 2013: 32).

Approaching the end of this discussion, the author would like to acknowledge some similarities between the core concepts identified in this project and the two papers. The first one, work of Lloyd et al. (2007), was a small scale case study and included only one participant with depression among others with more severe conditions with psychotic

features. However, the findings offered much substance to understanding of the arts potential to address mental health conditions. The authors identified specific themes in order to encapsulate participants' experience in arts therapeutic programme, which was not intended as arts therapy, but nevertheless offered opportunities for healing creative engagement. The authors speak, among others, about self-discovery, acceptance, hope and meaning. All of these concepts have been identified as core to this project.

The second extremely relevant article by Blomdahl et al. (2013) had been very recently published and discovered by the author just before the current thesis was complete. In this work the authors review studies in art therapy to extract the healing factors for depression. Interestingly, some of the factors identified are very similar in meaning to the core concepts, which emerged from this project. The authors list eight factors holding a particular therapeutic value for depression, among them: self-exploration, self-expression and communication. Similarities to the concepts emerging from current findings seem apparent. Sense of self, self-expression and reconnecting are the themes which seem to respectively correspond to the themes suggested by Blomdahl et al. (2013).

Although not an arts therapies literature, the recent work of the two modern philosophers (De Botton & Armstrong 2013), quite similarly proposes themes which according to authors explain the healing power of arts. The themes, emerging from very different philosophical and artistic inquiries, carry meanings very relevant to this project and further research in arts therapies for depression and seem to confirm the universal potential of arts to heal, especially if combined with guidance of a skilled therapist. (The themes identified by the authors include, among others: hope, rebalancing, self-understanding, appreciation and growth.)

6. Conclusions

In the very last section of this thesis, an attempt to draw final conclusions meaningful for a diverse audience will be made and recommendations for future research projects will be indicated in hope that this modest in scope work will be followed by further studies, which could eventually lead to a true understanding of arts therapies role in the challenge to treat depression.

As a reminder, this project aimed to achieve two core aims:

- 1) to describe arts therapies practice with depression in the UK
- 2) to evaluate this practice in a pilot study

These aims were approached through the use of mixed methodologies and methods and in consequence the project followed a design complex yet relevant to the subject studied.

6.1 Core findings

Findings in this project originated from the analysis of various quantitative and qualitative datasets and therefore offered multiple perspectives and allowed for an understanding much deeper than could have been achieved through the use of a single methodology. Main findings in this research may be summarised as follows:

- I. Depression is a condition very commonly encountered by arts therapists in their practice and often masked by other physical or mental health problems. Although there are no specific guidelines available to arts therapists and they use varied approaches and tools in their work with depression, many practitioners tend to address the condition through group work, using integrative psychotherapeutic approach and often focusing on particular issues, including time and reconnection.

II. A brief group art therapy may be a safe and valuable intervention for adults suffering from depression. The pilot study concluded that the treatment offered specific benefits, including decrease in symptoms of depression and improvement in subjectively perceived wellbeing. Importantly, group art therapy promoted meaningful connections with other participants as opposed to common in depression tendency to isolate. Moreover, understanding of concepts core to depression by the therapist increases the value of arts therapy intervention.

III. A larger study evaluating arts therapies for depression is feasible provided that certain improvements to the current research design are made (as suggested in section 4.4).

6.2 General considerations for future studies

As indicated in the last point, further research in the field is not only feasible but highly recommended, while the findings revealed numerous aspects of knowledge, which may potentially be explored much further to offer an even deeper understanding. General considerations for future studies will now be discussed and more specific recommendations will follow.

First of all, although conducting RCTs in psychotherapy carries recognised challenges (Bamford 2009, Bateman 2010: 258), this PhD work hoped to demonstrate that there is a potential for creatively designed clinical trials to offer meaning for various audiences, including practitioners in arts therapies.

Secondly, two sequential phases of the project hoped to indicate priorities in arts therapies research, giving its relatively young stage of development. In order to contribute to the development of evidenced-based practice, arts therapies researchers need to be clear in terms of the content of their studies and (however understandably difficult that is) define interventions to be examined and this project aimed to do just that. However, it is acknowledged that this aim could only partially be met and instead

of methodological perfection, opportunities for improvements were observed. For instance, future studies may consider specifying intervention even further, possibly indicating not only the therapy type and mode of delivery, but also its theoretical background and any other information which would make the intervention replicable and a possible prototype for future studies and clinical practice. Purely as an example, “brief interpersonal group art therapy” may be examined rather than a more generally considered “arts therapies” as in the initial design of the current study.

Another insight from this research suggests that complexity of both the condition in focus and arts therapies practice itself may need to be addressed in future studies through the use of innovative research designs, which would be appropriately endowed to capture the subtlety of the therapy process as well as contribute more scientific evidence to the discussion on effectiveness of arts therapies. Such creative approach to research brings inevitable challenges but it should also be stressed that arts therapists are among the practitioners best equipped to embark on furthering understanding using creative methods. Grainger (1999: 17) notices that “an imaginative approach knows where to begin – you begin between and among” and thus, arts therapists seem to be in an ideal position to explore the possibilities of own practice in a creative way.

Further conclusion may be that in psychotherapy research challenges seem to be a part of the process while it is obvious that studies require complex ethical approvals, need to be planned especially carefully as to avoid risks of psychological distress to participants and the researchers and most often are not readily supported by funders. Moreover, outcomes of psychotherapy studies may not necessarily be easily specified and often are difficult to interpret. In its essence, such research is bound to be critically scrutinised, as would likely be imaginative research designs. However, an old truth seems to be that a potential for large benefits brings large challenges. Psychotherapy, especially including creative components, may offer such benefits. It is hoped that one of the conclusions from this project would be that opening towards innovative methodological approaches could potentially offer understandings of increased quality to the questions of highest importance in psychotherapy.

As a brief reminder, potential methodological and practical improvements to any future studies willing to explore the benefits of arts therapies for depression further were highlighted in sections 3.5 and 4.4.

6.3 Recommendations for further research

The author acknowledges that this project generated more questions than it provided answers. This was in a sense its role, as a modest pilot study. However, if this project may at all be considered successful, its value would possibly concern a few discoveries of what is still to be discovered. Thus, further research is most strongly recommended.

Generally it may be concluded that while it remains unclear whether arts therapies are effective in the treatment of depression, brief group art therapy intervention offered in this project has proven not to be harmful for adults suffering from depression. Further research, including a randomised controlled trial and employing mixed methodology, is now recommended, which would draw on the promising results to establish whether the benefits observed are likely to be caused by the intervention itself. Besides, more research of a higher methodological quality could possibly conclude whether arts therapies may have an impact on anxiety levels and subjective wellbeing of adult sufferers of depression.

In addition to the above general recommendation, more specific suggestions for potential research were identified and will now be listed for clarity. These proposals concern the three main areas of inquiry:

I Arts therapies practice with depression

Although the current study contributed to knowledge in this area (Zubala et al. 2013), further investigations are recommended.

1. Qualitative studies (possibly involving interviews with arts therapists who work primarily with depression) are recommended to expand the knowledge on practice gained through this project. It is also advisable that further research explores similarities and differences between arts therapies disciplines.
2. In addition to generating new knowledge, it is recommended that systematic reviews of available literature on arts therapies practice are undertaken, following the example of Blomdahl et al. 2013. Such reviews would enable systematisation of currently fragmented knowledge initiated with this project.

II Evaluation of arts practice with depression

The current project offered a comprehensive evaluation of a brief group art therapy for depression. It measured outcomes indicating change, evaluated client experience and offered insights into the therapy process. However, a specific type of intervention was offered which may not adequately represent the usual art therapy practice. Limitations of this small scale pilot project lead to further need of quality research.

3. Further efficacy and eventually effectiveness studies are recommended in all of arts therapies disciplines. It is recommended that interventions to be used in future studies are standardised to enable replications. It is additionally suggested that further research explores the possibility of adapting therapies such as IPT (interpersonal psychotherapy), DIT (Dynamic Interpersonal Therapy) or Mentalisation-Based techniques for the use in arts therapies research and practice.
4. It is recommended that future research on evaluation of arts therapies practice for depression involves client experience. Such data may be obtained through interviews, questionnaires or arts-based methods. As this project led to a conclusion that time may be required for participants of arts therapies to consolidate their experience, collection of accounts of client experiences may be considered in a follow-up instead (or in addition) to an immediate evaluation after the therapy.
5. Due to the complex presentation of depression and the need and challenge to relate common in adult depression sufferers, further research may consider narrowing the focus to either mild, moderate or severe forms of the condition, encouraging more homogeneous groups of clients and potentially benefiting the study and the participants. Alternatively, other factors increasing potential for therapeutic success in brief arts therapies may be explored.

III Additional areas for research consideration

The creative process of investigating solutions to the two core research questions allowed for further questions to emerge, indirectly related to both the practice and the evaluation.

6. It is recommended to further explore the suitability of both individual and group arts therapies for depression, since the findings from this project and literature remain inconclusive (e.g. Dokter 1996). Brief individual therapy preceding group treatment may potentially be considered in future studies.
7. Since an issue of often impaired creativity in depression was raised, it is recommended that future research explores this subject further and possibly offer solutions as to how self-expression may be safely encouraged in the treatment of depression. A question put forward by one of the participants in this project may be considered: “How can art therapy lead you towards that [creative] state rather than require it at the outset?”
8. Core concepts identified in this project may potentially be further explored through qualitative or arts-based inquiries. Furthering understanding of what exactly works in arts therapies practice with depression has been postulated by Maratos et al. (2011). Creative inquiries into the healing factors in arts therapies practice with depression are encouraged.

6.4 Impact and implications

Possibly the largest value of the current project lies in its creativeness in approaching a relatively new field of study and in its potential for both academic and clinical implications. Essentially, this research contributes new knowledge to the field of arts therapies and adds to the discussion on best treatment choices in addressing depression. It also opens the potential for arts therapies to be more widely considered as a treatment option within mainstream healthcare, provided that it is appropriately followed by further, much expected and encouraged, research.

In its essence, this project offers the first comprehensive description of arts therapies practice in the UK. It also confirms the potential of this type of psychotherapeutic intervention to not only be safe and acceptable by clients/patients, but also effective in alleviating depression and improving wellbeing.

Shaping a strong basis for further explorations in the form of larger RCTs constitutes a particular value of this project, which demonstrates that creative research designs may not only be relevant but indeed superior in attempts to expand knowledge in the field of arts therapies and psychotherapy in general. Potential of successfully utilising mixed methodologies for the area has been revealed and creative research approaches, combining quantitative, qualitative and arts-based methods, are hoped to be similarly adopted by other researchers in the field.

6.5 The journey continues

He never fell, never slipped back, never flew.

(John Steinbeck “East of Eden”)

The three year long project has brought many dilemmas and no fewer insights. It has now finished and concludes with this thesis, which the author considers to be a prelude to further research travels. She also believes that exploration of the vast territories of psychotherapy research and advancing research in arts therapies is an adventure which should be shared.

Some of the findings from this project have already been published (Zubala et al. 2013; Zubala & Karkou 2014) and throughout the duration of her PhD the author has strived to communicate the progress of this research to diverse audiences during conferences in the UK and abroad, where posters were presented (British Psychological Society Annual Conferences: Glasgow 2011, London 2012, Harrogate 2013; 12th International Forum on Mood and Anxiety Disorders: Barcelona 2012; 12th European Arts Therapies Conference: Paris 2013). Further dissemination of findings and insights gained is planned. In addition to verbal and written material, arts are also intended to be present in the process of

communication of the findings, intentionally encouraging the audience to complete the meaning for themselves (Rust 2007: 69). In this way, this research hopes to be accessible and comprehensible to various audiences, including not only medical professionals or therapists with arts background but also interested clients, their families and the general public.

The author hopes that the journey will be continued in further research projects and that she would be able to share them with other travellers: researchers, arts therapists, health professionals, participants and anyone interested in advancing knowledge in how arts may offer their infinite potential to psychotherapy. While she acknowledges that challenges in research in this particular field are inevitable, the author hopes to encourage more creatively designed studies. Knowing that mistakes will be made along the way, she intends to travel further.

References

- Abraham, K. (2011) *Selected Papers on Psychoanalysis*. London: Karnac Books.
- Aldridge, D., Brandt, G., Wohler, D. (1990) Toward a common language among the creative art therapies. *The Arts in Psychotherapy*, 17(3), 189–195. DOI:10.1016/01974556(90)90001-7.
- American Psychiatric Association (2013) *Diagnostic and statistical manual of mental disorders: DSM-5*. Arlington: American Psychiatric Association.
- American Psychological Association, Society of Clinical Psychology (2007) Short-Term Psychodynamic Therapy for Depression [Online]. Available at: http://www.div12.org/PsychologicalTreatments/treatments/depression_psychodynamic.html (Accessed: 2 July 2012).
- Anderson, I. M. (2011) Principles of therapy. In: Friedman, E. S., Anderson, I. M., *Handbook of Depression*. London: Springer.
- Ando, M., Imamura, Y., Kira, H., Nagasaka, T. (2013) Feasibility and efficacy of art therapy for Japanese cancer patients: A pilot study. *The Arts in Psychotherapy*, 40(1), 130–133. DOI:10.1016/j.aip.2012.12.007.
- Angermeyer, M., Holzinger A., Matschinger H., Stengler-Wenzke K. (2002) Depression and quality of life: results of a follow-up study, *International Journal of Social Psychiatry*, 48(3), 189–199.
- Ankarberg, P., Falkenström, F. (2008) Treatment of depression with antidepressants is primarily a psychological treatment, *Psychotherapy*, 45(3), 329–339. DOI:10.1037/a0013309.
- Applied Health Sciences (Mental Health) University of Aberdeen (2011) *Assessing the validity of the PHQ-9, HADS, BDI-II and QIDS-SR16 in measuring severity of depression in a UK sample of primary care patients with a diagnosis of depression*. Aberdeen: NHS Quality Improvement Scotland.
- Bamford, B. (2009) Critiquing evidence-based treatments from the perspective of an RCT clinician, *Clinical Psychology Forum*, 201.
- Bar-Sela, G., Atid, L., Danos, S., Gabay, N., Epelbaum, R. (2007) Art therapy improved depression and influenced fatigue levels in cancer patients on chemotherapy, *Psycho-Oncology*, 16(11), 980–984.
- Barkham, M., Stiles, W., Connell, J., Twigg, E., Leach, C., Lucock, M., ... Angus, L. (2008) Effects of psychological therapies in randomized trials and practice-based studies. *British Journal of Clinical Psychology*, 47(4), 397–415.
- Barry, D. (2006) Dramatherapy for Women with Postnatal Depression, *Dramatherapy*, 28(3), 3–9. DOI:10.1080/02630672.2006-2007.9689701.

- Batcup, D. (2008) Evidence for the effectiveness of DMP with adult inpatients in a ward for adults with mental health problems in London, *E-motion*, 18(4), 10-13.
- Bateman, A., Brown, D., Pedder, J. (2010) *Introduction to psychotherapy: an outline of psychodynamic principles and practice*. New York: Routledge.
- Beck, A. T., Steer, R. A. & Brown, G. K. (1996) *Beck Depression Inventory Manual*, 2nd edition. San Antonio, TX: Psychological Corporation.
- Becker, H. S. (1977) *Sociological work: Method and substance*. Oxford: Transaction Books.
- Beebe, L., Wyatt, T. (2009) Guided imagery & music: using the Bonny Method to evoke emotion & access the unconscious, *Journal of Psychosocial Nursing & Mental Health Services*, 47(1), 29–33.
- Biesta G.J.J., Burbules N.C. (2004) *Pragmatism and Educational Research*. Lanham, MD: Rowman & Littlefield Publishers.
- Blatt, J. (1996) Dance movement therapy. In: C. Cordess & M. Cox (eds.) *Forensic psychotherapy: Crime, psychodynamics and the offender patient*, Vol. 2: *Mainly practice*. Forensic focus series. No. 1. London: Jessica Kingsley Publishers, 567-569.
- Bliss, S. Wilborn, B. (1992) The art process in therapy, *TCA Journal*, 20(2), 3-8.
- Blomdahl, C., Gunnarsson, A. B., Guregård, S., Björklund, A. (2013) A realist review of art therapy for clients with depression, *The Arts in Psychotherapy*, 40(3), 322–330. DOI:10.1016/j.aip.2013.05.009.
- Bodner, E., Iancu, I., Gilboa, A., Sarel, A., Mazor, A., Amir, D. (2007) Finding words for emotions: The reactions of patients with major depressive disorder towards various musical excerpts. *The Arts in Psychotherapy*, 34(2), 142–150.
- Booth, J. M. (1998) The Paradise program: A new music program for Guided Imagery and Music. *Journal of the Association for Music & Imagery*, 6, 15–35.
- Bosch van den, J., Hales, H. & Philpot, M. (2005) Dramatherapy with older people suffering from functional mental disorders, *Psychogeriatrics Polska*, 2(4), 341-348.
- Branch, J. (1992) Depression and feminine personality development. *Pratt Institute Creative Arts Therapy Review*, 13, 9–15.
- Brandes, V., Terris, D. D., Fischer, C., Loerbroks, A., Jarczok, M. N., Ottowitz, G., Thayer, J. F. (2010) Receptive Music Therapy for the Treatment of Depression: A Proof-of-Concept Study and Prospective Controlled Clinical Trial of Efficacy. *Psychotherapy and Psychosomatics*, 79(5), 321–322. DOI:10.1159/000319529
- Braun, V., Clarke, V. (2006) Using thematic analysis in psychology, *Qualitative Research in Psychology*, 3(2), 77–101. DOI:10.1191/1478088706qp063oa.
- Brauninger, I. (2010) *Dance therapy. Improving quality of life and stress management*. Unpublished.
- British Association of Art Therapists (2010) *What are the arts therapies?* [Online]. Available at: <http://www.baat.org/ArtsTherapies2010Flyer.pdf> (Accessed: 12 November 2010).

- Brooks, D. Stark, A. (1989) The effect of dance/movement therapy on affect: A pilot study, *American Journal of Dance Therapy*, 11(2), 101-112.
- Burns, D. S. (2001) The effect of the bonny method of guided imagery and music on the mood and life quality of cancer patients. *Journal Of Music Therapy*, 38(1), 51–65.
- Busch, F. N., Rudden, M., Shapiro, T. (2004) *Psychodynamic treatment of depression*. Arlington, VA: American Psychiatric Publishing, Inc.
- Bush, C. A. (1988) Dreams, Mandalas, and music imagery: Therapeutic uses in a case study. *The Arts in Psychotherapy*, 15(3), 219–225.
- Byrne, L. A. (1982) Music therapy and reminiscence: A case study. *Clinical Gerontologist: The Journal of Aging and Mental Health*, 1(2), 76–77.
- Castillo-Perez, S., Gomez-Perez, V., Calvillo Velasco, M. Perez-Campos, E., Mayoral, M.-A. (2010) Effects of music therapy on depression compared with psychotherapy. *The Arts in Psychotherapy*, 37(5), 387–390. DOI: 10.1016/j.aip.2010.07.001.
- Cattanach, A. (1999) *Process in the arts therapies*. London: Jessica Kingsley Publishers.
- Centers for Disease Control and Prevention (2012) *Current Depression Among Adults* [Online]. Available at: <http://www.cdc.gov/Features/dsDepression/> (Accessed: 30 July 2012).
- Chan, M. F., Chan, E. A., Mok, E., Tse, F. Y. K. (2009) Effect of music on depression levels and physiological responses in community-based older adults. *International Journal of Mental Health Nursing*, 18(4), 285–294.
- Chandraiah, S., Ainlay Anand, S., & Avent, L. C. (2012) Efficacy of Group Art Therapy on Depressive Symptoms in Adult Heterogeneous Psychiatric Outpatients, *Art Therapy: Journal of the American Art Therapy Association*, 29(2), 80–86.
- Charmaz, K. (2008) Grounded theory, In: Smith, J. A. (ed.) *Qualitative psychology: a practical guide to research methods*. London: Sage Publications.
- Chen, X. (1992) Active music therapy for senile depression. *Chinese Journal Of Neurology And Psychiatry*, 25(4), 208.
- Chisolm, S. (2007) Creative arts therapies. In: Chisolm, S. *The Health Professions: Trends and Opportunities in U.S. Health Care*. London: Jones & Bartlett Publishers.
- Chisholm, D., Diehr, P., Knapp, M., Patrick, D., Treglia, M., Simon, G. (2003) Depression status, medical comorbidity and resource costs Evidence from an international study of major depression in primary care (LIDO), *The British Journal of Psychiatry*, 183(2), 121–131. DOI:10.1192/02-224.
- Chou, K.-R., Lin, Y. (2012) P-444 - The effectiveness of group music therapy to improve depression and cognition status in elderly persons with dementia, *European Psychiatry*, 27, Supplement 1, 1. DOI:10.1016/S0924-9338(12)74611-4.

- Chu, H., Yang, C.-Y., Lin, Y., Ou, K.-L., Lee, T.-Y., O'Brien, A. P., & Chou, K.-R. (2013) The Impact of Group Music Therapy on Depression and Cognition in Elderly Persons With Dementia: A Randomized Controlled Study, *Biological Research For Nursing*.
- Clinical Outcomes in Routine Evaluation (2001) *CORE System*. Available at: <http://www.coreims.co.uk/index.php> (Accessed: 8 January 2011).
- Clinical Standards Advisory Group (2000) *Services for people with depression. A summary of the CSAG report on services for people with depression*. London.
- Coleman, V. D., Farris-Dufrene, P. (1996) *Art Therapy and Psychotherapy: Blending Two Therapeutic Approaches*. London: Routledge.
- Colucci, E. (2010) Arts-based research in cultural mental health, In: Y. Kashima, E. Kashima, R. Beatson (Eds.), *Steering the cultural dynamics: Selected papers from the 2010 Congress of the International Association for Cross-Cultural Psychology*. Melbourne, Australia: International Association for Cross-Cultural Psychology [Online]. Available at: <http://www.iaccp.org> (Accessed: 16 May 2013).
- Cook, C., Heath, F., Thompson, R. L. (2000) A Meta-Analysis of Response Rates in Web- or Internet-Based Surveys, *Educational and Psychological Measurement*, 60(6), 821-836.
- Cooke, M., Moyle, W., Shum, D., Harrison, S., Murfield, J. (2010) A randomized controlled trial exploring the effect of music on quality of life and depression in older people with dementia. *Journal of Health Psychology*, 15(5), 765-776.
- Coreno, C. A., & Ursuline College. (2007) *Using art therapy to decrease depression with adults in a partial hospitalization program*, [Dissertation] Masters Abstracts International.
- Crabtree B. F., Miller, W. L. (1999) *Doing Qualitative Research*, London: Sage Publications.
- Crespo, M. M. (2006) *Effects of culturally specific dynamically oriented group art therapy with immigrant Latinas*. [Dissertation] ProQuest Information & Learning, US. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psych&AN=2006-99022-210&site=ehost-live>.
- Creswell, J. (2009) *Research design. Qualitative, Quantitative, and Mixed Methods Approaches*. London: Sage Publications.
- Creswell, J. (2010) *How To Write a Mixed Methods Journal Article for Submission*. [Presentation] Research Forum, University of Manitoba, Canada, March 26th.
- Creswell, J., Garrett, A. (2008) The "movement" of mixed methods research and the role of educators, *South African Journal of Education*, 28(3), 321-333.
- Creswell, J., Klassen, A., Clark, K., Smith, K. (2010) *Best Practices for Mixed Methods Research in the Health Sciences*. Report commissioned by: Office of Behavioral and Social Sciences Research (OBSSR) [Online]. Available at: http://obssr.od.nih.gov/mixed_methods_research/pdf/Best_Practices_for_Mixed_Methods_Research.pdf (Accessed: 12 July 2013).

- Dalley, T. (1980) Assessing the therapeutic effects of art: An illustrated case study, *The Arts in Psychotherapy*, 7(1), 11-17.
- Davies, A. (1995) The acknowledgement of loss in working through depression, *British Journal of Music Therapy*, 9, 11-16.
- Daykin, N., Byrne, E., Soteriou, T., O'Connor, S. (2008) Review: The impact of art, design and environment in mental healthcare: a systematic review of the literature: Reviews. *Perspectives in Public Health*, 128(2), 85-94.
- De Botton, A., Armstrong, J. (2013) *Art as therapy*. London: Phaidon Press Limited.
- De l' Etoile, S. K. (2002) The effectiveness of music therapy in group psychotherapy for adults with mental illness. *The Arts in Psychotherapy*, 29(2), 69-78.
- Denny, J. M. (1968) Case study: Art therapy in the counselling of a university student. *Bulletin of Art Therapy*, 7(2), 94-99.
- Depression Alliance Scotland (2011) *About Depression*. Available at: http://www.dascot.org/depression/about_depression.htm (Accessed: 20 January 2011)
- Depression guide (2005) *Depression*. Available at: <http://www.depression-guide.com/depression-definition.htm> (Accessed: 12 November 2010)
- Desseilles, M., Chang, T., Piguet, C., Bertschy, G., Dayer, A. G. (2012) A three-dimensional model of thoughts: Insight into depression, *Psychopathology*, 45, 203-214.
- Detweiler-Bedell, J. B., Detweiler-Bedell, B., Baugher, A., Cohen, M., Robertson, J. (2013) Using Message Framing to Promote Social Support in Depression: When Misery Makes Better Company (Report), *Psychological Studies*, 1, p. 38.
- Dobrzynska, E., Wiecko, R., Cesarz, H., Rymaszewska, J., Kiejna, A. (2006) Music therapy and cognitive-behavioral therapy for older persons suffering from depression. *Psychogeriatrics Polska*, 3(2), 105-112.
- Dokter, D. (1996) Being together briefly: One-on-one brief dramatherapy with clients hospitalized for chronic or reactive depression, In: Gersie A. (ed.) *Dramatic approaches to brief therapy*. London: Jessica Kingsley Publishers, 188-200.
- Dozois, D. J. A., Dobson, K. S., Ahnberg, J. L. (1998) A psychometric evaluation of the Beck Depression Inventory-II, *Psychological Assessment*, 10 (2), 83-89.
- Driessen, E., Cuijpers, P., de Maat, S., Abbass, A., de Jonghe, F., Dekker, J. (2010) The efficacy of short-term psychodynamic psychotherapy for depression: a meta-analysis, *Clinical Psychology Review*, 30(1), 25-36.
- Dulwich Centre (2012) *What are externalising conversations?* Available at: <http://www.dulwichcentre.com.au/externalising.html> (Accessed: 2 July 2012).
- Edwards D. (1996) Why don't Arts Therapists do research?, In: Payne, H. *One river many currents: Handbook of inquiry in the arts therapies*. London: Jessica Kingsley Publishers.
- Eisner, E. W. (2002) *The Arts and the Creation of Mind*. London: Yale University Press.

- Emunah, R. (1994) *Acting for real: drama therapy process, technique, and performance*. New York: Brunner-Routledge.
- Erkkilä, J., Punkanen, M., Fachner, J., Ala-Ruona, E., Pöntiö, I., Tervaniemi, M., ... Gold, C. (2011) Individual music therapy for depression: randomised controlled trial. *The British Journal Of Psychiatry: The Journal Of Mental Science*, 199, 132–139.
- Erkkilä, J., Gold, C., Fachner, J., Ala-Ruona, E., Punkanen, M., Vanhala, M. (2008) The effect of improvisational music therapy on the treatment of depression: Protocol for a randomised controlled trial. *BMC Psychiatry*, 8.
- Etherington, K. (2004) *Becoming a Reflexive Researcher - Using Our Selves in Research*. Jessica Kingsley Publishers.
- Evans, D. (2003) Hierarchy of evidence: a framework for ranking evidence evaluating healthcare interventions, *Journal Of Clinical Nursing*, 12(1), 77-84.
- Field, W., Kruger, C. (2008) The effect of an art psychotherapy intervention on levels of depression and health locus of control orientations experienced by Black women living with HIV. *South African Journal of Psychology*, 38(3), 467–478.
- Finlay, L. (2002) 'Outing' the Researcher: The Provenance, Process, and Practice of Reflexivity. *Qualitative Health Research*, 12(4), 531–545. doi:10.1177/104973202129120052.
- Finlay, L., & Gough, B. (2008) *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*. John Wiley & Sons.
- Fisch, H. U., Frey, S., Hirsbrunner, H. P. (1983) Analyzing nonverbal behavior in depression. *Journal of Abnormal Psychology*, 92(3), 307–318.
- Fleuridas, C., Nelson, T. S., Rosenthal, D. M. (1986) The Evolution Of Circular Questions: Training Family Therapists, *Journal of Marital and Family Therapy*, 12(2), 113–127. DOI:10.1111/j.1752-0606.1986.tb01629.x.
- Forrest, G. (1978) An art therapist's contribution to the diagnostic process. *American Journal of Art Therapy*, 17(3), 99–105.
- Forrester, A.M., Johnson, D.R. (1996) The role of dramatherapy in an extremely short-term in-patient psychiatric unit, In: A. Gersie (ed.) *Dramatic approaches to brief therapy*. London England: Jessica Kingsley Publishers, 125-138.
- Foster, J., Budge, K., Bell, S., Price, J., Goodwin, G., Geddes, J. (2011) Refining a mood monitoring system for bipolar disorder: User experiences of True Colours, *Clinical Psychology Forum*, Supplement 1: DCP Annual Conference 2010.
- Frankel, R. (1999) Standards of qualitative research, In: Crabtree B. F., Miller, W. L. *Doing Qualitative Research*, London: Sage Publications.
- Freeth, R. (2007) *Humanising psychiatry and mental health care: The challenge of the person-centred approach*. Milton Keynes, United Kingdom: Radcliffe Publishing.

- Friedman, E. S. (2011) Other treatments, In: Friedman, E. S., Anderson, I. M., *Handbook of Depression*. London: Springer.
- Gask, L., Coventry, P. (2012) Person-centred mental health care: the challenge of implementation. *Epidemiology and Psychiatric Sciences*, 21, 139-144, DOI:10.1017/S2045796012000078.
- Gersie, A. (1996) *Dramatic Approaches to Brief Therapy*. Jessica Kingsley Publishers.
- Geue, K., Goetze, H., Buttstaedt, M., Kleinert, E., Richter, D., Singer, S. (2010) An overview of art therapy interventions for cancer patients and the results of research. *Complementary Therapies in Medicine*, 18(3-4), 160–170.
- Ghaemi, S. N. (2003) The Slings and Arrows of Outrageous Fortune. Depression, In: Ghaemi, S. N. *The Concepts of Psychiatry: A Pluralistic Approach to the Mind and Mental Illness*. Baltimore: Johns Hopkins University Press.
- Ghaznavi, S., Witte, J. M., Levy, R. A., Roffman, J. L. (2012) Bridging Technology and Psychotherapy: Toward Investigating Psychological and Neural Correlates of Psychodynamic Psychotherapy. In: Levy R. A., Ablon, J. S., Kachele, H. *Psychodynamic Psychotherapy Research. Evidence-Based Practice and Practice-Based Evidence*. Springer Publications. DOI: 10.1007/978-1-60761-792-1.
- Giatsi Clausen, M., Nicol, M., Gill, J. (2010) *The appeal of pragmatism for research employing a mixed methodology*, in 6th Mixed Methods International Conference, July 7-11, 2010, University of Leeds, UK in collaboration with Johns Hopkins Bloomberg School of Public Health, Baltimore. [Unpublished, Online]. Available at: <http://eresearch.qmu.ac.uk/1953/> (Accessed: 22 November 2012).
- Gilroy, A. (2006) *Art Therapy, Research and Evidence-based Practice*. London: Sage Publications.
- Ginsburgs, V. H., Goodill, S. W. (2009) A dance/movement therapy clinical model for women with gynecologic cancer undergoing high dose rate brachytherapy. *American Journal of Dance Therapy*, 31(2), 136–158.
- Gold, C., Solli, H. P., Krüger, V., Lie, S. A. (2009) Dose–response relationship in music therapy for people with serious mental disorders: Systematic review and meta-analysis, *Clinical Psychology Review*, 29(3), 193–207.
- Goldberg, F. S., Hoss, T. M., Chesna, T. (1988) Music and imagery as psychotherapy with a brain damaged patient: A case study. *Music Therapy Perspectives*, 5, 41–45.
- Goldstein-Roca, S., Crisafulli, T. (1994) Integrative creative arts therapy: A brief treatment model. *The Arts in Psychotherapy*, 21(3), 219–222.
- Gotlib, I. H., Hammen C. L. (2009) *Handbook of depression*. New York: The Guilford Press.
- Grainger, R. (2008) Dramatherapy and cognitive readjustment, *Counselling Psychology Review*, 23(3), 40-46.
- Grainger, R. (1999) *Researching the Arts Therapies: Dramatherapist's Perspective*. London: Jessica Kingsley Publishers.

- Greenberg, J. R., Mitchell, S. A. (1983) *Object Relations in Psychoanalytic Theory* (1 edition.). US, Cambridge: Harvard University Press.
- Grocke, D., Bloch, S., Castle, D. (2009) The effect of group music therapy on quality of life for participants living with a severe and enduring mental illness, *Journal of Music Therapy*, 46(2), 90-104.
- Groenlund, E., Renck, B., Vaboe, N. G. (2006) *How depressed teenage girls can be helped by dance movement therapy*, Presentation on the 2nd International Research Colloquium in Dance Therapy, 10-11 Feb.
- Guba, E. G. (1981) Criteria for assessing the trustworthiness of naturalistic inquiries, *Educational Communication and Technology Journal*, 29, 75–91.
- Guetin, S., Florence, P., Gabelle, A., Touchon, J., Bonté, F. (2011) Effects of music therapy on anxiety and depression in patients with Alzheimer's disease: A randomized controlled trial, *Alzheimer's & Dementia*, 7(4, Supplement), e49. DOI:10.1016/j.jalz.2011.09.204.
- Gunther, C., Holter, G. (2006) *Outcome Factors of DMT: A Pilot-Study with Depressive Patients*, Presentation on the 2nd International Research Colloquium in Dance Therapy, 10-11 Feb.
- Gussak, D. (2009) Comparing the effectiveness of art therapy on depression and locus of control of male and female inmates, *The Arts in Psychotherapy*, 36 (4), 202-207.
- Gussak, D. (2006) Effects of art therapy with prison inmates: A follow-up study, *The Arts in Psychotherapy*, 33(3), 188-198.
- Hagen, B. (2007) Measuring melancholy: a critique of the Beck Depression Inventory and its use in mental health nursing, *International Journal of Mental Health Nursing*, 16(2), 108-115.
- Hamamci, Z. (2006) Integrating psychodrama and cognitive behavioral therapy to treat moderate depression, *The Arts in Psychotherapy*, 33 (3), 199-207.
- Hamilton, C., Hinks, S., Petticrew, M. (2003) Arts for health: still searching for the Holy Grail. *Journal of Epidemiology and Community Health*, 57(6), 401–402. DOI:10.1136/jech.57.6.401
- Hammen, C., Watkins, E. (2007) *Depression*, 2nd ed. London: Psychology Press.
- Hanser, S. B., Thompson, L. W. (1994) Effects of a music therapy strategy on depressed older adults. *Journals of Gerontology*, 49(6), 265–269.
- Haywood Rolling, J. (2010) A Paradigm Analysis of Arts-Based Research and Implications for Education, *Studies in Art Education*, 51(2), 102-114.
- Health & Care Professions Council (2012) *Registration statistics*. Available at: <http://www.hpc-uk.org/publications/foi/index.asp?id=625> (Accessed: 5 March 2013).
- Health Professions Council (2013) *Arts therapists. Standards of proficiency*. London: Health Professions Council.

- Heber, L. (1993) Dance movement: A therapeutic program for psychiatric clients. *Perspectives in Psychiatric Care*, 29(2), 22–29.
- Heenan, D. (2006) Art as therapy: an effective way of promoting positive mental health? *Disability & Society*, 21(2), 179–191. DOI:10.1080/09687590500498143.
- Hendricks, C. B., Bradley, L. J. (2005) Interpersonal theory and music techniques: A case study for a family with a depressed adolescent. *The Family Journal*, 13(4), 400–405.
- Hershman, J., Lieb, J. (1998) *Manic depression and creativity*. Amherst, NY: Prometheus Books.
- Hervey, L. W. (2000) *Artistic inquiry in dance/movement therapy: creative research alternatives*. Springfield: Charles C Thomas Publisher.
- Hsu, W., Lai, H. (2004) Effects of music on major depression in psychiatric inpatients, *Archives Of Psychiatric Nursing*, 18(5), 193-199.
- Hwang, E.-Y., Oh, S.-H. (2013) A Comparison of the Effects of Music Therapy Interventions on Depression, Anxiety, Anger, and Stress on Alcohol-Dependent Clients: A Pilot Study, *Music & Medicine*, 5(3), p. 136.
- Ibarra-Rovillard, M. S., Kuiper, N. A. (2011) Social support and social negativity findings in depression: Perceived responsiveness to basic psychological needs, *Clinical Psychology Review*, 31(3), 342–352. DOI:10.1016/j.cpr.2011.01.005.
- Improving Access to Psychological Therapies, NHS (2013) *Interpersonal Psychotherapy for depression (IPT)*. Available at: <http://www.iapt.nhs.uk/workforce/high-intensity/interpersonal-psychotherapy-for-depression/> (Accessed: 7 April 2013).
- Isserow, J. (2013) Between water and words: Reflective self-awareness and symbol formation in art therapy. *International Journal of Art Therapy*, 18(3), 122–131. DOI:10.1080/17454832.2013.786107.
- Jeong, Y. et al. (2005) Dance movement therapy improves emotional responses and modulates neurohormones in adolescents with mild depression, *International Journal of Neuroscience*, 115(12), 1711-1720.
- Johnson, B., Christensen, L. (2010) *Educational Research: Quantitative, Qualitative, and Mixed Approaches*. London: SAGE.
- Johnstone, M. (2007) *I Had a Black Dog*. London: Robinson Publishing.
- Jones, N. A., Field, T. (1999) Massage and music therapies attenuate frontal EEG asymmetry in depressed adolescents. *Adolescence*. 34(135), 529-534.
- Jongsma, A. E., Peterson, L. M., Bruce, T. J. (2006) Depression, In: Jongsma, A. E., Peterson, L. M., Bruce, T. J. *The complete adult psychotherapy treatment planner*, New York: John Wiley and Sons.
- Jung, C. G., Chodorow, J. (1997) *Jung on active imagination*. Princeton, N.J.: Princeton University Press.

- Jung, C. G., Shamdasani, S. (2009) *The red book. Liber novus*. New York: W.W. Norton & Co.
- Kaplowitz, M. D., Hadlock, T. D., Levine, R. (2004) A comparison of Web and mail survey response rates, *Public Opinion Quarterly*, 68(1), 94-101.
- Karkou, V., Martinsone, K., Nazarova, N., Vaverniece, I. (2011) Art Therapy in the Postmodern World: Findings from a Comparative Study across the UK, Russia, and Latvia, *The Arts in Psychotherapy*, 38(2), 86-95.
- Karkou, V., Sanderson, P. (2006) *Arts Therapies: A Research-based Map of the Field*. London: Churchill Livingstone.
- Kelly C. (2010) Postmodernist Approaches to Mixed Methods Research, In: Hesse-Biber S. N. *Mixed Methods Research: Merging Theory with Practice*. New York: The Guilford Press.
- Kendrick T. (2009) Individual treatment decisions: guidelines and clinical judgement, In: Gask L., Lester H., Kendrick T., Peveler R. (eds.) *Primary care mental health*. London: The Royal College of Psychiatrists.
- Kessler, R. C., Chiu, W., Demler, O., Walters E. E. (2005) Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the national comorbidity survey replication, *Archives of General Psychiatry*, 62(6), 617–627. DOI:10.1001/archpsyc.62.6.617
- King N. (2011) *Template analysis* [Online]. Available at: http://www2.hud.ac.uk/hhs/research/template_analysis/index.htm (Accessed: 26 June 2012).
- Klein, M., Mitchell, J. (1991) *The selected Melanie Klein / edited by Juliet Mitchell*. London: Penguin.
- Klerman, G. L., Weissman, M. M., Rounsaville, B. J., Chevron, E. S. (1994) *Interpersonal Psychotherapy of Depression: A Brief, Focused, Specific Strategy*. Oxford: Rowman & Littlefield Publishers.
- Knill, P. J., Levine, E. G., Levine, S. K. (2005) *Principles and Practice of Expressive Arts Therapy: Towards a Therapeutic Aesthetics*. London: Jessica Kingsley Publishers.
- Koch, S., Morlinghaus, K., Fuchs, T. (2007) The joy dance: Specific effects of a single dance intervention on psychiatric patients with depression, *The Arts in Psychotherapy*, 34 (4), 340-349.
- Körlin, D., Nybäck, H., Goldberg, F. S. (2000) Creative arts groups in psychiatric care: Development and evaluation of a therapeutic alternative. *Nordic Journal of Psychiatry*, 54(5), 333–340.
- Kossak, M. (2012) Art-based enquiry: It is what we do!, *Journal of Applied Arts & Health*, 3(1), 21–29. DOI:10.1386/jaah.3.1.21_1.
- Kroenke, K., Spitzer, R.L., Williams, J.B. (2001) The PHQ-9: validity of a brief depression severity measure, *Journal Of General Internal Medicine*, 16 (9), 606-13.

- Kumar, G., Singh, B. K. (2013) To Access the Role of Music Therapy in Depression and Their Comparison with Drug Therapy, *International Journal of Pharmaceutical Sciences & Research*, 4(8), 3099-3102.
- Lai, Y. (1999) Effects of music listening on depressed women in Taiwan, *Issues in Mental Health Nursing*, 20(3), 229-246.
- Lambert, M. J., Davis, M. J. (2007) Treatment for depression: What the research says. In: Davidson, M. A. R. R. *Comparative Treatments of Depression: A Practitioner's Guide to Comparative Treatments* (1st ed.). US: Springer Publishing Co Inc.
- Lancaster G., Dodd S., Williamson P. (2004) Design and analysis of pilot studies: recommendations for good practice, *Journal of Evaluation in Clinical Practice*, 10 (2), 307-312.
- Landgarten, H. (1983) Art psychotherapy for depressed elders, *Clinical Gerontologist: The Journal of Aging and Mental Health*, 2(1), 45-53.
- La Torre, M. A. (2000) A Holistic View of Psychotherapy: Connecting Mind, Body, and Spirit, *Perspectives in Psychiatric Care*, 36(2), 67-68. DOI:10.1111/j.1744-6163.2000.tb00693.x.
- La Torre, M. A. (2003) The use of music and sound to enhance the therapeutic setting, *Perspectives in Psychiatric Care*, 39(3), 129-131.
- Laugharne R. (2002) Psychiatry, postmodernism and postnormal science. *Journal of the Royal Society of Medicine*, 95 (4), 207-210.
- Leach, C., Lucock, M., Barkham, M., Stiles, W. B., Noble, R., Iveson, S. (2006). Transforming between Beck Depression Inventory and CORE-OM scores in routine clinical practice. *British Journal of Clinical Psychology*, 45(2), 153-166. DOI:10.1348/014466505X35335
- Leavy, P. (2009) *Method Meets Art: Arts-based Research Practice*. London: Guilford Press.
- Ledger, A., Edwards, J. (2011) Arts-based research practices in music therapy research: Existing and potential developments, *The Arts in Psychotherapy*, 38(5), 312-317. DOI:10.1016/j.aip.2011.09.001.
- Lemma, A., Target, M., Fonagy, P. (2011) The Development of a Brief Psychodynamic Intervention (Dynamic Interpersonal Therapy) and Its Application to Depression: A Pilot Study, *Psychiatry: Interpersonal & Biological Processes*, 74(1), 41-48. DOI:10.1521/psyc.2011.74.1.41.
- Levy, F. J. (1995) *Dance and other expressive art therapies: when words are not enough*. New York: Routledge.
- Liebmann, M. (2007) *Art Therapy for Groups. A handbook of themes and exercises*. Howe: Routledge.
- Lin, M. et al. (2010) Pivotal moments and changes in the bonny method of guided imagery and music for patients with depression, *Journal of Clinical Nursing*, 19(7-8), 1139-1148.
- Lincoln, Y. S. (1995) Emerging criteria for quality in qualitative and interpretive research, *Qualitative Inquiry*, 1, 275-289.

- Llewellyn-Jones, S., Donnelly, P. (2000) Diagnosing and treating depression: A holistic approach is recommended, *British Medical Journal*, 320(7249), p. 1602. DOI:10.1136/bmj.320.7249.1602.
- Lloyd, C., Wong, S., Petchkovsky, L. (2007) Art and recovery in mental health: a qualitative investigation. *British Journal of Occupational Therapy*, 70(5), 207–214.
- Luyten, P., Blatt, S. J. (2011) Psychodynamic Approaches to Depression: Whither Shall We Go?, *Psychiatry: Interpersonal & Biological Processes*, 74(1), 1-3. DOI:10.1521/psyc.2011.74.1.1.
- MacDonald, R. A. R., Kreutz, G., Mitchell, L. (2012) What is music, health, and wellbeing and why is it important? In: MacDonald, R. A. R., Kreutz, G., Mitchell, L. (eds.) *Music, health, and wellbeing*. Oxford: Oxford University Press.
- Mala, A., Karkou, V., Meekums, B. (2012) Dance/Movement Therapy (D/MT) for depression: A scoping review, *The Arts in Psychotherapy*, 39(4), 287–295. DOI:10.1016/j.aip.2012.04.002.
- Malchiodi, C. A. (2003) *Handbook of art therapy*. New York: The Guilford Press.
- Mander G. (2006) *A Psychodynamic Approach to Brief Therapy*. London: Sage Publications.
- Mann, J. (1980) *Time-Limited Psychotherapy*. Harvard University Press.
- Manning, M. (1994) *Undercurrents: A Therapist's Reckoning With Her Own Depression*. Canada: HarperCollins Publishers.
- Maratos, A., Crawford, M. J., Procter, S. (2011) Music therapy for depression: it seems to work, but how?, *The British Journal Of Psychiatry: The Journal Of Mental Science*, 199(2), 92–93. DOI:10.1192/bjp.bp.110.087494.
- Maratos, A. S., Gold, C., Wang, X., Crawford, M. J. (2008) Music Therapy for Depression, *Cochrane Database Systematic Reviews*, 23 (1) CD004517.
- Maria Gisela, A. (2009) *Constructing life meaning through the use of dramatherapy in the case of depression*. [Unpublished Masters dissertation]. Available at: <http://www.proquest.co.uk/en-UK/products/dissertations/archivinggrad.shtml> (Accessed: 14 June 2012).
- Martinez, J. (2009) Is music therapy?, *Nephrology Nursing Journal*, 36 (3), 329-330.
- Mazza, N., Price, B. D. (1985) When time counts: Poetry and music in short-term group treatment. *Social Work with Groups: A Journal of Community and Clinical Practice*, 8(2), 53–66.
- McCaffrey, R. (2007) The effect of healing gardens and art therapy on older adults with mild to moderate depression. *Holistic Nursing Practice*, 21(2), 79–84.
- McCrone, P., Dhanasiri, S., Patel, A., Knapp, M., Lawton-Smith, S. (2007) *Paying the price. The cost of mental health care in England to 2026*. London: King's Fund.
- McNamee, C. M. (2004) Using both sides of the brain: Experiences that integrate art and talk therapy through scribble drawings. *Art Therapy*, 21(3), 136–142.

- McNiff, S. (2007) Art-based research, In: Knowles, J. G., Cole, A. L. *Handbook of the Arts in Qualitative Research: Perspectives, Methodologies, Examples, and Issues*. London: Sage Publications.
- McNiff, S. (1981) *The Arts and Psychotherapy*. Springfield: Charles C. Thomas.
- Meekums, B. (1996) Research as an act of creation, In: Payne, H. *One river many currents: Handbook of inquiry in the arts therapies*. London: Jessica Kingsley Publishers.
- Meekums, B., Karkou, V., Nelson, E. A. (2012) Dance movement therapy for depression. *Cochrane Database of Systematic Reviews*, Issue 6. Art.No.: CD009895. DOI: 10.1002/14651858.CD009895.
- Meldrum B. (1999) Research in the Arts Therapies, In: Cattanach, A. *Process in the arts therapies*. London: Jessica Kingsley Publishers.
- Mental Health Foundation (2006) *Dealing with depression*. London: Developing Patient Partnerships.
- Middleton, H., Shaw, I., Hull, S., Feder, G. (2005) NICE guidelines for the management of depression are clear for severe depression, but uncertain for mild or moderate depression, *British Medical Journal*, 330, 267-268.
- Mitic, N. (2006) Analysis of pictures of depressive patients from the point of view of mood and emotions. *Bulletin De La Société Des Sciences Médicales Du Grand-Duché De Luxembourg*, (2), 297–310.
- Montenegro Medina, M. A., Paredes Merino, A. (1996) El valor diagnóstico de la arteterapia en la severidad de la depresión [Diagnostic value of art therapy for severity of depression], *Revista de Psiquiatría Clínica*, 33(1-2), 43-49.
- Montgomery, E., Booth, R., Hutchinson, S. (2009) From a focus on function to rediscovering the self: a case report of an individual with post-stroke depression. *Therapeutic Recreation Journal*, 43(4), 25–41.
- Moorey, S. (2010) The Six Cycles Maintenance Model: Growing a 'Vicious Flower' for Depression. *Behavioural and Cognitive Psychotherapy*, 38(02), 173–184. doi:10.1017/S1352465809990580.
- Muller M. (2005) Action Research in supply chain management – an introduction, In: Kotzab H., Seuring S., Muller M., Reiner G. (ed.) *Research Methodologies in Supply Chain Management*. Heidelberg: Physica-Verlag.
- Myskja, A., Nord, P. (2008) The day the music died: a pilot study on music and depression in a nursing home. *Nordic Journal of Music Therapy*, 17(1), 30–40.
- National Institute for Health and Clinical Excellence (2009) *Costing statement: 'Depression' and 'Depression in adults with a chronic physical health problem'*. National Institute for Health and Clinical Excellence.
- National Institute for Health and Clinical Excellence (2009) *Depression. Quick reference guide. Treatment and management of depression in adults, including adults with a*

- chronic physical problem. NICE clinical guidelines 90 and 91. National Collaborating Centre for Mental Health.*
- National Institute for Health and Clinical Excellence (2009) *Depression. The treatment and management of depression in adults. NICE clinical guideline 90.* National Collaborating Centre for Mental Health.
- National Institute of Mental Health (2013) *Depression.* Available at: <http://www.nimh.nih.gov/health/publications/depression/index.shtml> (Accessed: 16 September 2013)
- NHS Choices (2013) *Controversy over DSM-5: new mental health guide.* Available at: <http://www.nhs.uk/news/2013/08august/Pages/controversy-mental-health-diagnosis-and-treatment-dsm5.aspx> (Accessed: 16 September 2013)
- NHS Quality Improvement Scotland (2012) *Promoting the Emotional Wellbeing of Adults with Mental Health Issues. The contribution of arts therapies.* [Leaflet from NHS Quality Improvement Scotland Practice Development Network: Arts Therapies].
- Nicholls, L. (2012). Art as Therapy for Depression; Themes of Darkness, Light and Hope, *Central Coast Express Advocate* (Sydney, Australia), 4 July, p. 40.
- Nicholson, L. (2012) *The journey home.* Available at: <http://www.hope4recovery.co.uk>.
- Odell, H. (1988) A music therapy approach in mental health, *Psychology of Music*, 16(1), 52-61.
- Odell-Miller, H. (1995) Why provide music therapy in the community for adults with mental health problems?, *British Journal of Music Therapy*, 9 (1), 4-10.
- Odell-Miller, H., Hughes, P., Westacott, M., (2006) An investigation into the effectiveness of the arts therapies for adults with continuing mental health problems, *Psychotherapy Research*, 16 (1), 122-139.
- O'Donohue, W., Graybar S. R. (2009) *Handbook of Contemporary Psychotherapy: Toward an Improved Understanding of Effective Psychotherapy.* Thousand Oaks: Sage.
- The Office for National Statistics (2001) *Mental health among adults* [Online]. Available at: <http://www.statistics.gov.uk/pdffdir/mhaa1201.pdf> (Accessed: 19 June 2013).
- Parr, H. (2006) Mental health, the arts and belongings. *Transactions of the Institute of British Geographers*, 31(2), 150–166. DOI:10.1111/j.1475-5661.2006.00207.x.
- Patry, J.-L. (2013) Beyond multiple methods: Critical multiplism on all levels, *International Journal of Multiple Research Approaches*, 7(1), 50-65.
- Pavlicevic, M., Trevarthen, C. (1989) A musical assessment of psychiatric states in adults. *Psychopathology*, 22(6), 325–334.
- Payne, H. (1992) *Dance movement therapy: theory and practice.* London: Routledge.
- Payne, H. (1993) *Handbook of Inquiry in the Arts Therapies: One River, Many Currents.* Jessica Kingsley Publishers.

- Perry, C., Thurston, M., Osborn, T. (2008) Time for Me: the arts as therapy in postnatal depression. *Complementary Therapies in Clinical Practice*, 14(1), 38–45.
- Pfizer Inc. (2012) *Instruction Manual for Patient Health Questionnaire (PHQ) and GAD-7 Measures* [Online]. Available at: <http://www.phqscreeners.com/instructions/instructions.pdf> (Accessed: 26 April 2013).
- Pickford, R. W. (1983) Music therapy with a Belgian patient: A follow-up. *British Journal of Projective Psychology & Personality Study*, 28(2), 31–35.
- Pittaway, S., Cupitt, C., Palmer, D., Arowobusoye, N., Milne, R., Holttum, S., ... Patrick, H. (2009) Comparative, clinical feasibility study of three tools for delivery of cognitive behavioural therapy for mild to moderate depression and anxiety provided on a self-help basis. *Mental Health in Family Medicine*, 6(3), 145–154.
- Pödlinger, W. (1986) The relation between depression and art. *Psychopathology*, 19(Suppl 2), 263–268.
- Price, J. S. (2009) *Creative healing: An expressive art therapy curriculum designed to decrease the symptoms of depression and anxiety*. [Unpublished Masters dissertation]. Prescott College.
- Primack, B.A. (2003) The WHO-5 Wellbeing Index performed the best in screening for depression in primary care, *ACP Journal Club*, 139(2), 48.
- The Quality Assurance Agency for Higher Education (2004) *Arts therapy. Benchmark statement: Healthcare programmes. Phase 2*. The Quality Assurance Agency for Higher Education.
- Radulovic R., Cvetkovic M., Pejovic M. (1997) *Complementary musical therapy and medicamentous therapy in treatment of depressive disorders*, WPA Thematic Conference. Jerusalem, November 1997.
- Rait, G., Walters, K., Griffin, M., Buszewicz, M., Petersen, I., Nazareth, I. (2009) Recent trends in the incidence of recorded depression in primary care, *The British Journal of Psychiatry*, 195, 520–524.
- Rajewski, A., Paterka, I., Fellman, B., Nalewajko, B. (1982) Aktywne formy muzykoterapii w leczeniu chorych depresyjnych, *Psychiatria Polska*, 16(5-6), 377–382.
- Rajewski, A., Walczak, D., Fellmann, B. (1981) Elementy rytmiki Dalcroze’a w leczeniu endogennych zespołów depresyjnych. *Psychiatria Polska*, 15(4-6), 393–398.
- Rawlinson, B. (1996) The seeds of the pomegranate: Images of depression. In: S. Mitchell (Ed.), *Dramatherapy: Clinical studies*. (151–178). London England: Jessica Kingsley Publishers.
- Redinbaugh, E.M. (1988) The use of music therapy in developing a communication system in a withdrawn, depressed older adult resident: A case study, *Music Therapy Perspectives*, 5, 82-85.

- Reinstein, M. (2002) 'When I am an old woman...' Using dramatherapy as a treatment for depression with functional elderly people, *Dramatherapy*, 24(2), 10–15. DOI:10.1080/02630672.2002.9689611.
- Reynolds, F., Lim, K. Prior, S. (2008) Narratives of therapeutic art-making in the context of marital breakdown: older women reflect on a significant mid-life experience, *Counselling Psychology Quarterly*, 21(3), 203–214.
- Ritter, M., Low, K. G. (1996) Effects of dance/movement therapy: A meta-analysis, *The Arts in Psychotherapy*, 23(3), 249–260.
- Rogers, C. (1951) *Client-centered therapy: its current practice, implications and theory*. London: Constable and Company.
- Rohricht F, Papadopoulos N, Priede S. (2013) An exploratory randomised controlled trial of body psychotherapy for patients with chronic depression. (unpublished, personal communication)
- Rorsman, B., Grasbeck, A., Hagnell, O., Lanke, J., Ohman, R., Ojesjo, L., & Otterbeck, L. (1990) A prospective study of first-incidence depression, *The British Journal of Psychiatry*, 156, 336–342.
- Rosen, D. H. (1993) *Transforming depression: Egocide, Symbolic Death, and New Life. A jungian approach using the creative arts*. New York: Tarcher/Putnam.
- Roth, A., Fonagy P. (1996) *What works for whom? A critical review of psychotherapy research*. New York: The Guildford Press.
- The Royal College of Psychiatrists (2010) *Depression* [Online]. Available at: <http://www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthproblems/depression/depression.aspx> (Accessed: 8 December 2010).
- Ruddick, F. (2010) Person-centred mental health care: myth or reality?, *Mental Health Practice*, 13(9), 24–28.
- Rust, C. (2007) How Artistic Inquiry Can Inform Interdisciplinary Research, *International Journal of Design*, 1(3), 69–76.
- Salvador-Carulla, L., Mezzich, J.E. (2012) Person-centred medicine and mental health, *Epidemiology and Psychiatric Sciences*, 21, 131–137, DOI:10.1017/S204579601200008X.
- Salzman, C. (1996). Treating the depressed artist. In: J. J. Schildkraut, A. Otero (Eds.), *Depression and the spiritual in modern art: Homage to Miró*. (57–66). Oxford England: John Wiley & Sons.
- Sandelowski, M. (1996) Using qualitative methods in intervention studies, *Research in Nursing & Health*, 19(4), 359–364. DOI: 10.1002/(SICI)1098-240X(199608)19:4<359::AID-NUR9>3.0.CO;2-H (Accessed: 25 June 2012).
- Schmais, C. (1985) Healing processes in group dance therapy, *American Journal of Dance Therapy*, 8(1), p. 17.

- Schnee, G. (1996) Drama therapy in the treatment of the homeless mentally ill: treating interpersonal disengagement. *The Arts in Psychotherapy*, 23(1), 53–60.
- Schulz, K. F., Altman, D. G., Moher, D. (2010) CONSORT Statement: updated guidelines for reporting parallel group randomised trials, *British Medical Journal*, vol. 340.
- Schwantes, M., McKinney, C. (2010) Music therapy with Mexican migrant farmworkers: A pilot study. *Music Therapy Perspectives*, 28(1), 22–28.
- Scott, J., Dickey, B. (2003) Global burden of depression: the intersection of culture and medicine, *The British Journal of Psychiatry*, 183, 92–94.
- The Scottish Government (2012) *Mental Health Strategy for Scotland: 2012-2015*. Edinburgh: Scottish Government. Available at: <http://www.scotland.gov.uk/Publications/2012/08/9714/downloads>.
- Scottish Intercollegiate Guidelines Network (2010) 114. *Non-pharmaceutical management of depression in adults. A national clinical guideline*. NHS Quality Improvement Scotland.
- Silverman, M. J. (2010) Applying levels of evidence to the psychiatric music therapy literature base, *The Arts in Psychotherapy*, 37(1), 1–7. DOI: 10.1016/j.aip.2009.11.005.
- Silverman, M., J. (2011) Effects of Music Therapy on Change and Depression on Clients in Detoxification, *Journal of Addictions Nursing*, 22(4), 185–192. DOI:10.3109/10884602.2011.616606.
- Simms, L., J., Prisciandaro, J., Krueger, R., F., Goldberg, D., P. (2012) The structure of depression, anxiety and somatic symptoms in primary care, *Psychological Medicine*, 42(1), 15–28. DOI:10.1017/S0033291711000985.
- Simon, G. E., Rutter, C. M., Peterson, D., Oliver, M., Whiteside, U., Operskalski, B., Ludman, E. J. (2013) Does Response on the PHQ-9 Depression Questionnaire Predict Subsequent Suicide Attempt or Suicide Death?, *Psychiatric Services. A Journal of the American Psychiatric Association*.
- Simons, H., McCormack, B. (2007) Integrating Arts-Based Inquiry in Evaluation Methodology. Opportunities and Challenges, *Qualitative Inquiry*, 13(2), 292–311.
- Skevington S.M., Lotfy M., O’Connell K.A. (2004) The World Health Organization’s WHOQOL-BREF quality of life assessment: Psychometric properties and results of the international field trial. A Report from the WHOQOL Group, *Quality of Life Research*, 13, 299–310.
- Spitzer, R.L., Kroenke K., Williams, J.B. (2006) A brief measure for assessing generalized anxiety disorder: the GAD-7, *Archives of Internal Medicine*, 166(10), 1092–7.
- Shankman, S. A., Klein, D. N. (2002) Dimensional diagnosis of depression: Adding the dimension of course to severity, and comparison to the DSM, *Comprehensive Psychiatry*, 43, 420–426. DOI:10.1053/comp.2002.35902.
- Spandler, H., Secker, J., Kent, L., Hacking, S., Shenton, J. (2007) Catching life: the contribution of arts initiatives to recovery approaches in mental health. *Journal of*

- Psychiatric and Mental Health Nursing*, 14(8), 791–799. DOI:10.1111/j.1365-2850.2007.01174.x.
- Spaniol, S. (2001) Art and mental illness: Where is the link? *The Arts in Psychotherapy*, 28(4), 221–231.
- Stacey, K., Hills, D. (2001) More Than Protest: Further Explorations of Alternative Metaphors in Narrative Therapy, *Australian & New Zealand Journal of Family Therapy*, 22(3), 120–128.
- Staricoff, R. L. (2004) *Arts in health: a review of medical literature*. London: Arts Council England.
- Stewart, N., McMullen, L., Rubin, L. (1994) Movement therapy with depressed inpatients: a randomized multiple single case design, *Archives of Psychiatric Nursing*, 8(1), 22-29.
- Stordahl, J. J. (2010) *The influence of music on depression, affect, and benefit finding among women at the completion of treatment for breast cancer*. [Dissertation] ProQuest Information & Learning, US. [Online] Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2010-99130-490&site=ehost-live>.
- Strassel, J., Cherkin, D., Steuten, L., Sherman, K., Vrijhoef, H. (2011) A systematic review of the evidence for the effectiveness of dance therapy. *Alternative Therapies in Health & Medicine*, 17(3), 50–59.
- Stuckey, H. L., Nobel, J. (2010) The Connection Between Art, Healing, and Public Health: A Review of Current Literature, *American Journal of Public Health*, 100(2), 254–263. DOI:10.2105/AJPH.2008.156497.
- Sudak, D. M. (2011) *Combining CBT and Medication: An Evidence-Based Approach*. New Jersey: John Wiley & Sons.
- Summer, L. (2011) Music therapy and depression: Uncovering resources in music and imagery, In: Meadows, A., *Developments in music therapy practice: Case study perspectives*. Barcelona: Barcelona Publishers, 486-500.
- Svensk, A., Oster I., Thyme K., Magnusson E., Sjodin M., Eisemann M., Astrom S., Lindh J. (2009) Art therapy improves experienced quality of life among women undergoing treatment for breast cancer: a randomized controlled study, *European Journal of Cancer Care*, 18(1), 69-77.
- Tashakkori A., Teddlie C. (2003) *Handbook of mixed methods in social & behavioral research*. London: SAGE Publications.
- Tashakkori A., Teddlie C. (1998) *Mixed Methodology: Combining Qualitative and Quantitative Approaches*. London: SAGE Publications.
- Taylor D. (2012) Psychoanalytic and Psychodynamic Therapies for Depression: The Evidence Base, In: Levy R. A., Ablon J. S., Kachele H. *Psychodynamic Psychotherapy Research. Evidence-Based Practice and Practice-Based Evidence*. Springer Publications. DOI: 10.1007/978-1-60761-792-1.

- Thabane L., Ma L., Chu R., Cheng J., Ismaila A., Rios L., Robson R., Thabane M., Giangregorio L., Goldsmith C. (2010) A tutorial on pilot studies: the what, why and how, *BMC Medical Research Methodology*, 10(1).
- Thorne, D. (2011) Images on the void: An enquiry into the nature of depression through reflections on five commonly presented images, *International Journal of Art Therapy*, 16(1), 20–29. DOI:10.1080/17454832.2011.570275.
- Thyme, K.E., Sundin E., Stahlberg G., Lindstrom B., Eklof H., Wiberg B. (2007) The outcome of short-term psychodynamic art therapy compared to short-term psychodynamic verbal therapy for depressed women, *Psychoanalytic Psychotherapy*, 21(3), 250-264.
- Tomlinson, K. L. (2011) *Working with the imaginal: Art-making and dialogue with figures of soul*. [Dissertation] ProQuest, UMI Dissertation Publishing.
- Tonn, C. (2003) Den Stillstand zum Klingen bringen: Depressionsspezifische Themen und deren Behandlung bei Patientinnen in einer musiktherapeutischen Gruppe. *Musiktherapeutische Umschau*, 24(2), 120–133.
- Trautmann-Voigt, S., Voigt, B., Lichtenberg, J. D., Fehlberg, W. (Trans). (2002) Zur Bedeutung von Bewegung und Raum in der Psychotherapie am Beispiel von Herrn K. *Self Psychology: European Journal for Psychoanalytic Therapy and Research*, 3(10), 491–514.
- Vaismoradi, M., Turunen, H., Bondas, T. (2013) Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study, *Nursing & Health Sciences*, 15(3), 398–405. DOI:10.1111/nhs.12048.
- Van den Bosch, J.-A., Hales, H., Philpot, M. (2005) Dramatherapy with older people suffering from functional mental disorders. *Psychogeriatrica Polska*, 2(4), 341–348.
- Van Tejlilingen, E. R., Hundley, V. (2001) The importance of pilot studies. *Social Research Update*. Issue 35.
- Walker, S., Read, S., Priest, H. (2013) Use of reflexivity in a mixed-methods study. *Nurse Researcher*, 20(3), 38–43.
- Wallace, J., Yorgin, P. D., Carolan, R., Moore, H., Sanchez, J., Belson, A., ... Arrington, D. (2004) The use of art therapy to detect depression and post-traumatic stress disorder in pediatric and young adult renal transplant recipients. *Pediatric Transplantation*, 8(1), 52–59. DOI:10.1046/j.1397-3142.2003.00124.x
- Walsh, L. (2009) *Depression care across the lifespan*. Chichester: Wiley-Blackwell.
- Wan, Y., Mao, Z., Qiu, Y. (2009) Influence of music therapy on anxiety, depression and pain of cancer patients [Chinese]. *Chinese Nursing Research*, 23(5A), 1172–1175.
- Warren, B. (2008) *Using the Creative Arts in Therapy and Healthcare: A Practical Introduction*. 3rd ed. London: Routledge.
- Weber, S. (2008) Visual images in research, In: Knowles, J. G., Cole, A. L. *Handbook of the arts in qualitative inquiry: perspectives, methodologies, examples, and issues*. London: Sage Publications.

- Williams, C. (2013) *Living life to the full* [Online]. Available at: <http://www.lltff.com> (Accessed: 17 July 2013).
- Winnicott, D. W. (1988) *Human nature*. London: Free Association Books.
- Witte, I. van H., Verburgt, J., Smeijsters, H., (2011) Music as life and lifeguard: Music therapy for an older adult with depression, In: Meadows, A., *Developments in music therapy practice: Case study perspectives*. Barcelona: Barcelona Publishers, 556-568.
- WHO-5 (2011) *WHO-Five Well-being Index (WHO-5)*. *WHO Major Depression Inventory (MDI)* [Online]. Available at: <http://www.who-5.org/> (Accessed: 1 March 2011).
- World Health Organization (2010) *Depression* [Online]. Available at: http://www.who.int/mental_health/management/depression/definition/en/ (Accessed: 12 March 2010).
- World Health Organization (1997) *The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research*. Geneva: World Health Organization.
- Xiong, L., Li, M., Li, Q. (2009) Influence of dance therapy on self-efficacy and rehabilitation of patients with depression [Chinese]. *Chinese Nursing Research*, 23(12A), 3138–3139.
- Yalom, I. D., Leszcz, M. (2005) *The theory and practice of group psychotherapy*. New York: Basic Books.
- Yun, G. W., Trumbo, C. W. (2000) Comparative Response to a Survey Executed by Post, E-mail, & Web Form, *Journal of Computer-Mediated Communication*, 6(1) [Online]. Available at: <http://jcmc.indiana.edu/vol6/issue1/yun.html> (Accessed: 12 July 2011).
- Zubala, A., MacIntyre, D. J., Gleeson, N., Karkou, V. (2013) Description of arts therapies practice with adults suffering from depression in the UK: Quantitative results from the nationwide survey, *The Arts in Psychotherapy*, 40(5), 458-464. DOI: 10.1016/j.aip.2013.09.003.
- Zuroff, D., Koestner, R., Moskowitz, D., McBride, C., Marshall, M., Bagby, R. (2007) Autonomous motivation for therapy: A new common factor in brief treatments for depression, *Psychotherapy Research*, 17(2), 137–148. DOI:10.1080/10503300600919380.

The Arts Therapies Survey 2011

--- Page 1 ---

Welcome to The Arts Therapies Survey 2011

Please, complete as fully as possible, making any further comments you wish.

All information you give is confidential.

For the purpose of this questionnaire, certain terms have been used. Please bear in mind these interpretations when completing the questionnaire.

Arts Therapies:	Music therapy, art therapy, dramatherapy and dance movement therapy.
Arts therapist(s):	Practitioner(s) using Arts Therapies (music therapists, art therapists, dramatherapists, dance movement therapists)
Client(s):	People you work with, including patients, children, students, etc.
Client group(s):	People you work with, who have similar characteristics, needs or difficulties.

If currently unemployed, please answer with respect to your last employment.

If you have not yet started working (e.g. just qualified), please answer with respect to your potential future practice.

--- Page 2 ---

A. General information about your practice

1 What is the main arts therapy type you are using in your practice?

- music therapy
- art therapy / art psychotherapy
- dramatherapy
- dance movement therapy / dance movement psychotherapy
- other (please specify):

2 What are the main types of difficulty of your clients? *(select all that apply)*

- learning difficulties
- physical/sensory difficulties
- mental health problems
- multiple difficulties
- social deprivation
- medical problems
- no apparent/specific difficulty
- other (please specify):

3 Of these, which would you regard as your main client group?

- learning difficulties
- physical/sensory difficulties
- mental health problems
- multiple difficulties
- social deprivation
- medical problems
- no apparent/specific difficulty
- other (please specify):

4 You usually work: *(select all that apply)*

- on a one-to-one basis
- with parent-child / families / couples
- with groups
- other (please specify):

5 What are the age ranges of the client groups you are working with? *(select all that apply)*

- children (up to 11 years)
- adolescents (11-16)
- young adults (17-25)
- adults (26-65)
- older people (over 65)

6 Where do you see your clients? *(select all that apply)*

- health service
- social service
- voluntary agency
- educational setting
- private agency
- private practice
- other (please specify):

7 Of these, which would you regard as your main working environment?

- health service
- social service
- voluntary agency
- educational setting
- private agency
- private practice
- other (please specify):

8 You usually work: *(select all that apply)*

- on your own
- with a team of other arts therapists
- with a team of other professionals
- other (please specify):

--- Page 3 ---

B. Theoretical influences

9 What are the main theoretical influences on your work? *(select all that apply)*

- specific artistic tradition
- specific arts therapies tradition
- areas not formulated as theories anywhere
- psychoanalytic theory
- psychodynamic theory
- group analytic theory
- object relation theory
- Kleinian theory
- work of Winnicott
- attachment theory
- Jungian symbol work
- developmental theories
- play therapy
- Gestalt
- transactional analysis theory
- Kelly's Personal Construct theory
- behavioural therapy
- eclectic approach
- integrative approach
- other (please specify) :

10 Comments on your main influences: *(Optional)*

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C. Therapeutic principles

Please indicate by ticking the appropriate box your degree of agreement/disagreement with these statements.

(A five-point answering scale is provided: SA = strongly agree, A = agree in most cases, U = uncertain: neither agree nor disagree, D = disagree in most cases, SD = strongly disagree)

11 Humanistic

- What I am working towards is a sense of responsibility.
- The purpose of the therapy has to do with the "wholeness".
- Arts therapies have to do with individuals becoming who they really are.
- The aim is facilitating awareness of another.
- One of my fundamental hypotheses is that there is a strong body-mind relationship.
- I am trying to offer the clients a learning experience.
- I am trying to respond with my whole self.

12 Psychoanalytic / psychodynamic

- I do analyse in a psychoanalytic way.
- I am trying to link the clients' past with their present lives.
- I am looking at the transference between client and therapist.
- Psychoanalytic theory provides me with an explanation of what is going on in the session.
- Therapeutic change is facilitated by achieving insight.
- I work quite hard verbally.

13 Developmental

- I hold developmental stages in mind most of the time.
- I am aware of the developmental stages my clients are at.
- The objectives are linked to the developmental stage the client is at.
- I use precise criteria when I evaluate.
- There is no resistance in me about evaluating therapy.

14 Artistic / creative

- The therapeutic process is always about encouraging clients to create something.
- I try to enable clients to really engage with the art process as fully as possible.
- I encourage clients to be as spontaneous as they possibly could be.
- My artistic background determines the techniques I use.
- I am much more active in the early stages of the therapy.
- I am trying to set up a metaphor for something that might happen in real life.

15 Active / directive

- Sometimes I will actively do artwork myself during the session.
- I may concentrate my work on physical aspects.
- I do not direct other than for basic safety.
- I do have certain techniques that I bring out when it is appropriate.
- I may concentrate my work on helping a client with some intellectual / cognitive aspects.

16 Eclectic / integrative

- I use a number of different approaches for each client.
- It depends which population I am working with, what sort of theoretical approach I am adopting.
- I do not think I have got one model that I follow.
- The clients I work with have taught me most of what I know.
- My ideas are designed in collaboration with the clients.

--- Page 5 ---

D. Assessment and evaluation

17 When is a client suitable for the arts therapy type you are offering? When / if:

(select all that apply)

- s/he is responsive to the art medium
- s/he is very well motivated
- we both feel we can work together
- s/he feels settled within an enabling environment
- there is a need for emotional outlet
- s/he is able to work spontaneously
- s/he is able to symbolise
- s/he has communication problems
- s/he struggles to find words for his/her feeling
- s/he uses words as defence against his/her feelings
- s/he is able to work with unconscious processes
- other reasons (please specify):

18 In order to evaluate the therapeutic work which areas do you usually focus on?

(select all that apply)

- ability to use facilities
- favoured instruments / media
- development of the art work
- emerged themes
- dynamic issues
- verbal / non-verbal communication
- transference / countertransference
- coping mechanisms
- resistance to work
- engagement with therapy process
- neurological issues
- changes in behaviour
- key issues for the client
- client's perception of progress
- other areas (please specify):

19 Comments on initial assessment and/or evaluation of the therapeutic process: *(Optional)*

20 Further comments on your practice: *(Optional)*

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E. Biographical information of Arts Therapies Practitioners

It would be greatly appreciated if you could supply the following details about yourself.

All information you give will be treated in the strictest confidence.

21 Sex

- female
- male
- other (please specify):

22 Age

- up to 30
- 31-40
- 41-50
- 51-60
- over 61

23 Years you have used Arts Therapies in your practice:

- up to 3
- 4-7
- 8-11
- 12-15
- more than 15

24 Academic and/or professional qualification in arts therapies:

25 Main artistic experience and/or qualifications: *(Optional)*

26 Other relevant experience and/or qualifications: *(Optional)*

--- Page 7 ---

F. Additional information for the purpose of current research in arts therapies and depression

This survey is a part of the PhD study concerning arts therapists' work with people suffering from depression. This research is undertaken at the Queen Margaret University, Edinburgh.

If you would like to know more about this project, you are welcomed to contact Ania Zubala, main investigator, at: azubala@qmu.ac.uk

27 Are there people who suffer from depression among your clients?

- yes
- no

(If answer is "yes" to question 22, all the following questions apply; if answer is "no" – only questions 23 and 24 apply.)

27a How would you describe the intensity of depression in majority of your depressed clients?

- mild
- moderate
- severe

27b Would you say that people who suffer from depression are your main client group?

- yes
- no

27c Please share any comments you might have on your work with people suffering from depression: *(Optional)*

28 Please provide your e-mail address *(Optional)*

29 We will only contact you for specific purposes you agree to be contacted for. Please state when you would like to be contacted *(select all that apply): (Optional)*

- I would like to be informed about the results and the progress of this research.
- I would be happy to be contacted you for an informal interview / e-mail correspondence regarding my work with depressed clients.
- I would like to be entered into a draw of a book "Art Therapies: A Research-based Map of the Field".

--- Page 8 ---

Thank you for taking time to complete this survey.

Your contribution to this research is highly appreciated.

Letter to Arts Therapies Associations

(date)

Dear (Name),

My name is Ania Zubala and I am a PhD research student at the Queen Margaret University, Edinburgh (Arts Therapies, School of Health Sciences). My research is supervised by Dr Vassiliki (Vicky) Karkou.

I have contacted you previously asking for your help in determining the number of registered (*art/music/drama/dance and movement –to choose relevant*) therapists. I am grateful for your response -this information has been very helpful in designing my study, which has recently gained ethical approval from the Queen Margaret University. I am now writing to you to ask for an even greater favour.

In the first stage of my research I aim to describe how arts therapists, of all four arts therapies disciplines recognised in the UK, work with clients suffering from depression. For this purpose I plan to issue a survey to all arts therapists registered in the UK for which I would like to ask for your help and appreciation. The questionnaire is interested in practical and professional aspects of arts therapies, including theoretical principles, aims, methodology and evaluation. It was developed by Karkou in 1996, revised in 2009 and adapted for the purpose of this research in 2011 to include additional items concerning work with depression. I have attached the questionnaire as pdf file for your information. The survey will be available for arts therapists online for a time of several weeks in May/June 2011 and could be accessed via a unique web link. Your help with making the survey available to as many (*art/music/drama/dance and movement –to choose relevant*) therapists as possible would be invaluable and crucial to this part of the research. Therefore, I would greatly appreciate if you could send an e-mail to all (*art/music/drama/dance and movement –to choose relevant*) therapists on your records containing an information letter, which I have attached to this message. I am asking you for this special favour for two reasons: I obviously cannot access the personal data of all registered arts therapists myself and, more importantly, your approval of this research is essential for this study and for me as a researcher.

I hope that the findings from this research will present a useful reference for arts therapists themselves and will be of an interest to other professionals working with depression, strengthening arts therapies position among valuable treatment options. The outcome from this part of the study is planned to be known by the end of 2011 and the results from the whole research on arts therapies and depression should be available by the end of 2013 as my PhD thesis and published in relevant journals and conferences. I will be very happy to inform you about the progress of this research in the meantime.

I would be grateful if you could let me know, whether this is something you might be able to help me with. Thank you for your time and understanding.

I am looking forward to hearing from you.

Kind Regards,

Ania Zubala

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Advertising of the survey through Arts Therapies Associations

Timeline of advertising by Arts Therapies Associations		
June 2011		
16.06	advert sent to BADth research network e-mail forum	
17.06	advertised by ADMP UK through e-mails and information on members' area of the website	
25.06	advertised in Approaches: Music Therapy & Special Music Education newsletter	
July 2011		
05.07	advertised by BAAT in e-Bulletin	
09.07	reminder sent by ADMP UK through e-mails	
11.07	advertised by BAMT in e-Bulletin	
?	advertised by BAMT in Newsletter	
August 2011		
02.08	reminder sent by SATF to members (e-mail)	
15.08	advertised by BADth in the newsletter, Prompt	
?	advertised in summer issue of e-Motion (ADMP journal)	

Modes of advertising			
arts therapy discipline	e-mail contact (confirmed)	newsletter/ e-Bulletin/ journal	other
art psychotherapy (AT)	144 members of BAAT	e-Bulletin (05.07)	info on members' website (21.06)
dance movement psychotherapy (DMP)	all members of ADMP	journal: e-Motion (?08)	info on members' website
music therapy (MT)		newsletter: Approaches (25.06) newsletter: BAMT (?07) e-Bulletin (11.07)	
dramatherapy (DT)	28 members of BADth	newsletter: Prompt (15.08)	research network e-mail forum

Other contacts:

SATF (06.07.2011, 18.08.2011)

NIGAT (21.07.2011, 18.08.2011)

Nordoff-Robbins (25.07.2011, 18.08.2011)

London Arts in Health Forum (18.08.2011)

Arts & Health South West (18.08.2011)

Arts Therapies Professional Associations in the UK:

BAAT – British Association of Art Therapists

BAMT – British Association for Music Therapy

ADMP UK – Association for Dance Movement Psychotherapy UK

BADth – British Association of Dramatherapists

Arts Therapies Survey 2011 – pilot letter

24th May 2011

Dear All,

You are kindly invited to take part in a **pilot survey** concerned with the practice of professional **Arts Therapists**. Your participation is greatly appreciated and will help ensure the quality of this survey, which will be used as part of my PhD study. This study has been approved by the QMU Research Ethics Panel.

About this questionnaire:

The questionnaire has been designed by Dr Vicky Karkou and first used in her PhD research in 1996. The results from the survey have been published in “Arts Therapies: A Research-based Map of the Field” by Karkou and Sanderson in 2006. The survey has been revised in 2009 and used to compare arts therapies practice in the UK and other countries. This version of the questionnaire is presented online for the first time. It also includes several new items which are concerned with arts therapies for people with depression in particular.

I would be grateful if you could complete the questionnaire and then answer several simple questions aiming **to evaluate it**. Please also make a note of the time when you start, as you will be asked how long it took you to complete the questionnaire.

Please use the link below to access the survey online:

https://surveys.qmu.ac.uk/arts_therapies_survey_pilot

If you have any questions about the survey or about this research, please contact either myself at AZubala@qmu.ac.uk or Dr Vicky Karkou, Research Supervisor, at VKarkou@qmu.ac.uk.

Thank you to all who take part for your time and contribution to this research.

Ania Zubala

PhD research student
Division of Nursing, Occupational Therapy and Arts Therapies
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azubala@qmu.ac.uk

Arts Therapies Survey – Pilot – evaluation items

Survey evaluation

Thank you for taking time to complete this questionnaire.

Please now answer the questions below to help us evaluate this survey.

1. Time needed to complete.

How long did it take you to complete this questionnaire? Please state time in minutes.

(blank space)

2. Mode of delivery

Do you agree or disagree with these statements?

(agree, neither agree nor disagree, disagree)

- Completing this questionnaire online was very convenient.
- I would rather complete this questionnaire on paper.

3. Content, structure and presentation

Please state whether you agree or disagree with the following statements.

Please also suggest what could be improved.

(agree, neither agree nor disagree, disagree + blank space for comments under each sentence.)

- Introduction was informative.
- Questions were worded properly.
- Instructions were clear.
- The questionnaire was well structured
- The content was well presented.

4. Other comments.

(blank space under each item)

What I **liked** about this survey:

What I **did not like** about this survey:

Any other comments?

Pilot survey evaluation - Contents:

I	Introduction	1
II	Time needed to complete the questionnaire	1
III	Mode of delivery	1
IV	Content, structure and presentation	2
V	Working with depression	2
VI	Other comments	3
VII	Final evaluation	4

I Introduction

The pilot for the Arts Therapies Survey 2011 was carried out in May/June 2011 for the duration of two weeks. On the 24th May, an email was sent to arts therapists at QMU asking them to take part in a survey and evaluate it. A reminder was then sent on the 28th May. Some of the arts therapists took their initiative to encourage their students and colleagues to take part. The pilot closed on the 7th June with 29 responses.

Majority of respondents were from art therapy / art psychotherapy background (23) and others represented dance movement psychotherapists (3) and music therapists (3). Dramatherapists did not take part in the pilot as they are not present among QMU staff.

II Time needed to complete the questionnaire

Answers to the question 30, asking how much time was spent on completing the questionnaire, ranged from 'up to 10 minutes' to '30 minutes', with majority of answers stating 10 minutes (15 participants) and four responses of 30 minutes. The mean has been calculated at 15.14 minutes and it has been decided the participants in the actual survey will be informed that completing the questionnaire will take around 15 minutes.

III Mode of delivery

Answers to question 31a and 31b clearly show that the participants valued the opportunity to complete this questionnaire online. 26 participants agreed that completing the questionnaire online was very convenient with 2 neither agreeing nor disagreeing. Nobody would rather complete this

Pilot survey evaluation

questionnaire on paper with 20 people disagreeing that this would be better and 5 stating that they neither agree nor disagree. It can be concluded that all of the participants accepted the online mode of delivery with majority of them clearly preferring this to the traditional paper mode.

It needs to be stressed, however, that the answers might have been different should the questionnaire be distributed in both modes during the pilot. It could be assumed that people who prefer paper delivery decided not to take part in the survey at all and could be, thus, underrepresented in the results. However, taking into account the general growing confidence in using technology, including e-mails and internet, it has been decided that delivering this survey online is appropriate and convenient for both the researcher and the participants.

IV Content, structure and presentation

The structure, content and presentation of this questionnaire were generally positively evaluated by the respondents. Between 24 and 29 participants agreed that the introduction was informative (question 32), instructions were clear (question 34), the questionnaire was well structured (question 35) and the content was well presented (question 36). Nobody disagreed with these statements and some respondents neither agreed nor disagreed (between 0 and 5).

23 people agreed that questions were worded properly, while two respondents disagreed. One person “felt that a number of the questions were unclear” and “was not sure of what really was being asked”. Another respondent added that “statements often felt closed and did not cover all of the approaches used within music therapy”. Other comments to the same question concerned the limiting amount of options for answers:

“(…) I found the tick options limiting and could have done with a category “agree in some cases”. To tick either “strongly agree or agree in most cases” did not give an accurate representation of my practice.”

“Some of the options given in relation to the approaches followed were not very clear.”

While the choices of answers might be limiting, only this way can they be compared and analysed quantitatively. It has been acknowledged that there were respondents who considered some of the statements / answers confusing. However, as all of the statements were worded by the therapists themselves and the majority of participants felt that the questions were worded properly, it has been decided that the wording is appropriate enough.

V Working with depression

The following comment was made to question 27 (section F), concerned with participants’ experience of working with depression:

“This category of depression is dependent on the label a client is given within a highly complex picture. Many clients I work with have a range of issues that include anxiety disorder, issues of substance misuse, dissociative disorders, personality disorder, eating disorders and depression. How can you identify ‘depression’ as a single disorder?”

This comment acknowledges the complexity of the problem of depression, including many types of this disorder, which should not be put into one category and the fact that depression is often inseparable from other psychological problems. This complexity of depression has been taken into account by the researcher and will hopefully be reflected in the interviews with arts therapists following the survey. The aim of the survey itself is to identify therapists who work with depression, however they interpret this term, and to provide initial picture of their practice. Clarification of this and specifics of their work will be explored later, in interviews.

VI Other comments

Some of the respondents commented on what they liked (7 participants) and what they did not like (4 participants) about the survey (questions 37, 38, 39).

Among negative comments were concerns with the need to provide specific, multiple-choice type answers:

"I did not like the requirement to provide tick-box answers for questions that were much more complex than could be relegated to a simple box-answer. I considered not completing the questionnaire because I felt that my answers were not (and because of the format, could not be) entirely accurate."

"It was hard and a little frustrating to have to fit my answers into the tick box options on offer."

However, two other respondents provided positive feedback for the same reasons, stating that they liked multiple choice ("I think I would have lost interest if asked for longer responses") and "short clear questions". Preference for either open or closed questions is dependent on each person's individual characteristics and therefore a compromise is not possible here. It has been decided that multiple choice questions are useful as they allow for comparison, while an option for open answer has been included in most questions to encourage those, who might feel limited by the need to 'tick boxes'. This type of design tries to respond to the different needs of participants.

One respondent stated that they found 'neither agree nor disagree' option confusing and suggested using 'agree sometimes' or 'disagree sometimes'. Such solution would work well if the scale was to expand from 5 to 7 items of a Likert scale. Still, the neutral option is required in such scaling. It has been decided that 5 items scale gives enough options and is less confusing for most people than longer scale.

In other comments, the respondents stated that they liked "thoughtfulness" and that the questionnaire "was very easy to fill in".

Other positive feedback from the participants includes comments on the valuable opportunity to take time to think about their practice:

"I liked the fact that it made me contemplate and rethink about my practice and my knowledge in relation to art therapy"

"It made me really think about my practice particularly in terms of my theoretical orientation"

“It was interesting to have to think about my practice in this way, and see if I could fit it into categories.”

These comments suggest that the survey has an additional value for some of the respondents and, by focusing on the therapeutic practice, makes them contemplate on their work, hopefully strengthening professional identity and personal awareness. Although this is not the main aim of this study, such effect is obviously welcomed and desirable in any professional environment and especially in psychotherapy.

VII Final evaluation

To summarise, the survey has been received very positively and valuable comments made by the respondents have been acknowledged. Following the pilot, the actual survey was launched on the 14th June and e-mails to professional Associations were sent on the same day.

Your practice with clients/patients with depression

(questions following the Arts Therapies Survey 2011)

Please answer these questions honestly and sharing as much or as little details as you find comfortable and/or appropriate. Spaces for entering text will expand if needed. (Please note that all answers will be fully anonymised and stored separately from your e-mail address.)

<p>1. What is the main therapy type you are using in your practice? (art psychotherapy / dance movement psychotherapy / music therapy / dramatherapy / other?)</p>
<p>2. Why do you work with people suffering from depression? (eg. personal interest, motivation; nature/requirement of work setting)</p>
<p>3. What are the main characteristics of your clients / patients other than depression? (eg. age groups, other prevailing conditions, referral procedures)</p>
<p>4. Are there any specific theoretical influences which you find especially useful in your work with people with depression? If so, what are they?</p>
<p>5. Are there any specific interventions and/or tools which you find most helpful and use most often in your practice? If so, what are they?</p>

6. What does **depression** mean to you as a therapist? How would you define / describe this condition based on your experience?

7. Do you encounter any specific **challenges** while working with people with depression? If so, what are they?

8. Do you experience any particular **rewards** from working with people with depression? If so, what are they?

9. Would you like to make any further comments on your practice with people who suffer from depression?

Thank you very much for taking your time to answer those questions and contributing to further development of research in arts therapies and depression.

Please send your responses back to: azubala@qmu.ac.uk by the end of December 2011.

Thank you.

Arts Therapies Survey 2011

A survey concerned with the practice of professional **Arts Therapists** has just been launched!

Please take part and contribute to the research held at the Queen Margaret University (Edinburgh) by Dr Vicky Karkou and Ania Zubala, a PhD student.

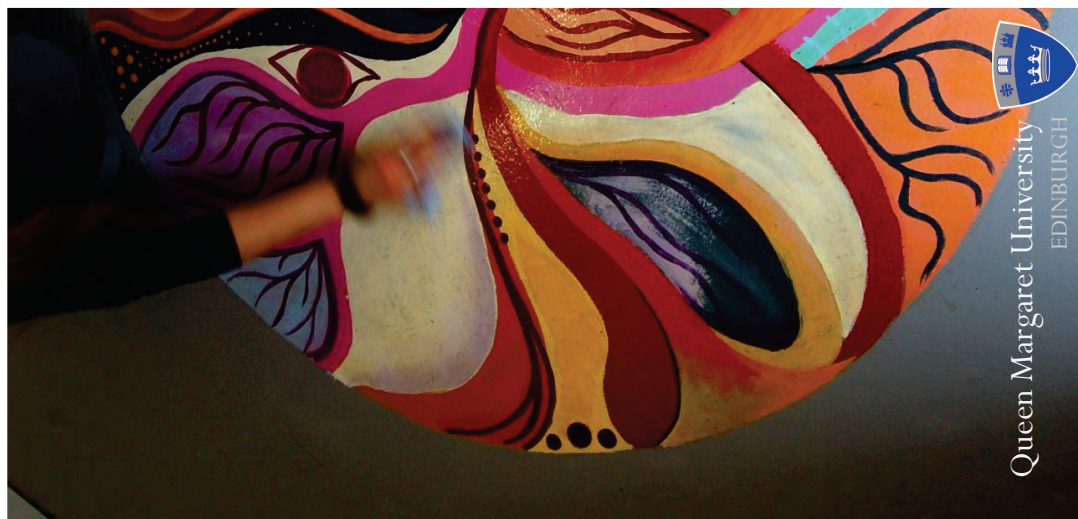
Under the following link, you will find the questionnaire which is a result of an ongoing attempt to facilitate exchange of opinions and knowledge among Arts Therapists. Completing this questionnaire will take you approximately 15 minutes. Please use the link below to access the survey online:

https://surveys.qmu.ac.uk/arts_therapies_survey_2011

One of the participants will receive the book "Arts Therapies: A Research-based Map of the Field".

Thank you to all who take part!

If you have any questions or would like more information about the survey or about this research, please contact either Ania Zubala at AZubala@qmu.ac.uk or Dr Vicky Karkou, Research Supervisor, at VKarkou@qmu.ac.uk.



14th June 2011

Dear Therapist,

You are kindly invited to take part in a **survey** concerned with your **practice as a professional Arts Therapist**.

Under the following link, you will find the questionnaire which is a result of an ongoing attempt to facilitate exchange of opinions and knowledge among Arts Therapists. The questionnaire, generated from therapists' own voices, has been designed by Dr Vicky (Vassiliki) Karkou and first used in her PhD research in 1996. The results from the survey have been published in "Arts Therapies: A Research-based Map of the Field" by Karkou and Sanderson in 2006. The survey has been revised in 2009 and used to compare arts therapies practice in the UK and other countries. Your participation will contribute to further research in the field and is greatly appreciated.

The results from the questionnaire will also be used as a part of a PhD study by Ania Zubala, a research student at the Queen Margaret University, Edinburgh. This new study is concerned with arts therapies for people with depression. For its purpose, several new items have been included in the last section of the questionnaire. The results from this survey may be used in other research in the field of arts therapies in the future and please take part, regardless of which client groups you work with.

This research has gained ethical approval from the Queen Margaret University Research Ethics Panel and has been accepted by relevant arts therapies associations (BAAT, ADMP UK, BADth and BAMT).

Completing this questionnaire will take you approximately 15 minutes.

Please use the link below to access the survey online:

https://surveys.qmu.ac.uk/arts_therapies_survey_2011

If you have any questions about the survey or about this research, please contact either Ania Zubala at AZubala@qmu.ac.uk or Dr Vicky (Vassiliki) Karkou, Research Supervisor, at VKarkou@qmu.ac.uk. If you would like to contact an independent person, who is not directly involved in this research, you are welcome to contact Ian McMillan at IMcmillan@qmu.ac.uk.

One of the participants will receive the book "Arts Therapies: A Research-based Map of the Field". If you wish to be included in the draw, please provide your e-mail address in the last section of the questionnaire.

Thank you to all who take part for your time and contribution to this research.

Kind Regards,

Ania Zubala

PhD research student
Division of Nursing, Occupational Therapy and Arts Therapies
School of Health Sciences, Queen Margaret University, Edinburgh EH21 6UU
azubala@qmu.ac.uk

E-mail to therapists in group D+

Dear Therapist,

I would like to kindly thank you for taking part in the **Arts Therapies Survey 2011** by which you have greatly contributed to the ongoing research on arts therapies at the Queen Margaret University, Edinburgh. I am now exploring the data from the Survey for the purpose of my PhD research on **arts therapies and depression**.

You have stated that clients/patients with depression are your main client group and agreed to be contacted for research purposes. I would therefore like to invite you to take part in the next stage of this study, which hopes to gain more insights from arts therapists concerning their work with depression specifically. I would be grateful if you could answer several questions about your practice with this client group. You can do this in one of two ways (whichever is more convenient for you) – either by completing a Word document attached or responding directly to this e-mail (you will find the questions below). I would appreciate if you could send your responses back to me by the end of December 2011. Please answer honestly, as the data will only be kept in fully anonymised format (e-mail addresses will be detached from responses). You are welcome to share as much or as little details as you find comfortable and appropriate. I understand that completing the form requires a significant amount of your time and, therefore, please feel free to end your involvement with this study here, if this proves too inconvenient task. With this awareness, I would be especially grateful if you decide to take part. As a symbolic ‘thank you’, all therapists who send their responses will be entered into a draw of illustrated books on the subject of depression.

Because of time constraints in this study, unfortunately I will not be able to conduct full interviews, but please let me know if you would prefer to talk on a telephone or speak to me in person (if you live in relative proximity of Edinburgh) and I will do my best to accommodate your preferences. In this case, please provide your telephone number and/or address.

Thank you in advance for your help in taking this important (I believe) research a step further. I will be happy to inform you about the progress of this study and share results, once known.

Kind regards,

Ania

Treatment manual

Arts therapies for Depression

(art psychotherapy and movement psychotherapy)

Introduction	1
1. Approaches and principles	2
2. Aims and methods	6
3. Life of the group	9
4. Session structure and activities	11
References	13

This document is intended to give guidance to both the therapist and the researcher, while preparing, facilitating and reflecting on the intervention to be applied to adults suffering from mild to moderate depression in the ‘Arts therapies for depression’ project. By no means does it aim to provide an exhaustive list of tools or activities to be used. Rather, it highlights the main theoretical underpinnings of both interventions, discusses the aims of the therapy in the specific context of adult depression, provides an overview of the expected life of the group, pictures the general structure of each session and suggests exemplary activities. Also, this manual does not aim to replace diverse reading of both theory and clinical case studies; whenever psychotherapeutic approaches or other clinical issues are mentioned, only some aspects of them, specifically applicable to work with depression, are discussed.

This treatment manual was developed, based on three main sources of knowledge and experience:

- specialist literature and current research on arts therapies, psychotherapy and depression
- current NHS guidelines for depression (NICE and SIGN) and manuals of arts therapies good practice
- findings from phase 1 of this research (nationwide survey of arts therapists, with 395 responses, of which 294 respondents have depressed people among their clients and 67 work with depression specifically)

This treatment manual consists of four sections, each focusing on a different aspect of the intervention and aiming to:

- provide theoretical and expert background of the intervention
(1. Approaches and principles)
- identify therapeutic aims, as relevant to adults suffering from depression
(2. Aims and methods)
- sketch the general group situation throughout the therapy, as expected in similar groups
(3. Life of the group)
- propose the application of specific structure within each session
(4. Session structure and activities).

The four sections will, therefore, shape the intervention, starting from its therapeutic background, through general ideas of group work to more specific applications in the particular situation of working with depression.

1. Approaches and principles

2

In this project, **group art and movement psychotherapies** will be offered to adults (6-8 participants in each group) suffering from depression. Both therapies will be **person-centred** (to the extent, which is achievable in a group settings) and will follow **psychodynamic** principles. Time constraints dictate that interventions will be **brief** (12 sessions over 6 weeks). The aforementioned principles will now be discussed in more detail.

Psychodynamic principles

The value of short term psychodynamic psychotherapy in the treatment of depression has been acknowledged in the health care provision in the UK (SIGN 2010, NICE 2009), based on rich research evidence that this type of psychotherapeutic treatment may bring substantial benefits for adults suffering from mild and moderate depression (Driessen et al. 2010).

Arts therapies generally tend to stem from a range of psychotherapeutic and philosophical traditions; diversity is an important characteristic of the field (Karkou & Sanderson 2006) and a single theoretical background is not usually desirable or even appropriate. While different disciplines of arts therapies have become influenced by certain theories to different degrees, both art and movement psychotherapies have psychodynamic and humanistic traditions well established in their backgrounds. According to Karkou & Sanderson (2006), both theoretical backgrounds underpin arts therapists' practice, with psychoanalytic/psychodynamic principles valued most by art psychotherapists and humanistic ideas preferred by dance movement

psychotherapists. However, arts therapists, who work with mental health problems, generally show “a higher preference for psychoanalytic/psychodynamic perspectives” (Karkou & Sanderson 2006, pp. 99). This tendency seems appropriate and in line with research evidence, which supports the use of verbal psychodynamic psychotherapies for depression (Roth & Fonagy 1996).

Arts therapists, who responded to the nationwide survey, identified various approaches, on which they base their practice with psychodynamic and humanistic ideas most popular. Their theoretical background generally contained more than one approach or, as one of the respondents stated, usually was an “eclectic mix”. However, humanistic and psychoanalytic factors (factors in the survey identified by Karkou in 1998) were the most common among arts therapists, who work mainly with depression. Similarly, traditions of psychodynamic and attachment theories seemed to be the most popular among the given approaches (respectively, over 80% and over 70% respondents chose these theories as theoretical influences), with the work of Winnicott in the third place (over 60% agreement). In addition, the work of Carl Gustav Jung and Donald Winnicott again were most often mentioned in open-ended questions.

The following psychodynamic principles will apply to arts therapies offered in this project:

1. The unconscious is manifested within the arts (in art-making process and/or in artistic product).
2. The therapy aims to facilitate insight (seen as necessary for positive change).
3. The relationship (which includes transference) between the client, the therapist and the arts is dynamic and crucial for the therapy process.
4. The relationships with self and others are reflected in the relationships within the group.
5. While arts therapies offer a unique opportunity for expression and sharing through arts media, the verbal component remains important for the therapy.

3

Person-centred approach

The person-centred approach, advocated by Rogers (1951) and steaming from the humanistic tradition, has become increasingly popular among psychotherapists and other health professionals in the last decades. It has not only been widely present and valued in addressing mental health problems (Salvador-Carulla & Mezzich 2012) but has also been recognised as a much wider concept, an approach which can be introduced in the “health care contexts outside therapy relationships” (Freeth 2007, 2; also Gask & Coventry 2012).

As mentioned earlier, humanistic tradition is widely present within the field of arts therapies and in the nationwide survey, arts therapists, who work specifically with depression, agreed with humanistic and psychodynamic principles most strongly. Also, arts therapists do not necessarily need to acknowledge a predominant humanistic orientation in their practice to be willing and almost naturally adopting person-centred approach, which often guides the work

of therapists, who may practice primarily within other theoretical frameworks (Karkou & Sanderson 2006: 78).

The following humanistic principles will apply to arts psychotherapies offered in this project:

1. Human beings have natural potential to develop and strive for meaningful fulfilment, self-realisation and wholeness.
2. Self-expression and creativity play important role in lives of all people and therefore should be encouraged in therapy.
3. Group therapy offers a safe space for participants to interact here-and-now and facilitates awareness of another.
4. Therapy's attention is directed towards growth, highlighting positive, healthier aspects of self.

It is also understood that person-centred approach will manifest itself in the therapeutic relationship between the participants and the therapist and the researcher. It is expected to include qualities listed by Rogers (1995): acceptance, genuineness and empathy. While these qualities are not necessarily easy to implement in standard mental health care (Ruddick 2010), both the researcher and the therapist will strive to honestly communicate with participants, be non-judgemental and offer understanding throughout the process of the therapy and the research in general.

Group work

4

In this project, group arts psychotherapies (of up to 8 participants in each group) will be offered.

There is a well-documented research evidence in support of positive implications of group psychotherapy for depression (e.g. McDermut et al. 2001; MacKenzie & Grabovac 2001; Levkovitz et al. 2000). Although factors which may predict responsiveness to group therapy rather than individual therapy are not clear (McDermut et al. 2001), in this project a clinical assumption was made that group therapy may offer additional benefits not achievable in individual therapy and especially relevant to adults suffering from depression, like an opportunity to share experiences, to receive feedback and to practice relating to others in a safe and accepting environment. Some of the unique therapeutic factors of group therapy discussed by Yalom (Yalom & Leszcz 2005) and expected to characterise the therapy offered in this project include:

- universality (realisation of having problems, fears, feelings similar to others)
- cohesion (a sense of solidarity and feeling of belonging, valuing the group)
- altruism (helping and supporting others, following from isolation and preoccupation with oneself)
- interpersonal learning and giving and receiving critical feedback
- catharsis (release of emotional tension originating in self-disclosure)
- corrective recapitulation of family dynamics (identifying and amending the dysfunctional patterns in a more open and experimental atmosphere)

- imitative behaviour (modelling another's behaviour, relating patterns or recovery skills)

According to the nationwide Survey, arts therapists, who work with depression specifically, seem to value the benefits of group work more than therapists, who do not have depressed clients. However, it should be mentioned that, while group work may be especially helpful in tackling some aspects of depression, it may be more challenging for the participants than individual therapy. The great potential of group process possibly requires more effort and determination on the client's side, as one of the paradoxes of depression needs to be challenged: the need to relate and engage versus the avoidance of others and tendency to isolation.

Group work principles and therapeutic factors, with their specific meaning in the context of depression, will be discussed further in section 3. *Life of the group*.

Brief approach to therapy

In this project, brief approach to therapy will be adopted, while the therapy will last for 6 weeks (12 sessions).

Brief approach to psychotherapy reflects the modern way of life and has become popular in the recent decades for various reasons, including practical and economic concerns as well as its high effectiveness for some clients. Providing psychotherapy for a short and strictly limited period of time has, however, been criticised by some practitioners and theorists, especially those of strong psychodynamic background and utilising arts and creativity in their practice. Some even state that certain conditions, including depression, require a longer-term approach (Taylor 2012).

Significance of the issue of time in a therapy of depressed clients is also one of the main findings of the Survey. In arts therapists' responses to the Survey, time seems essential for the success of therapy and most therapists recommend longer therapy time for depression. While arts therapies are more often offered as longer term treatments, this project aims to assess whether, with careful planning and the best possible use of time, brief therapy may offer a more accessible and economical option.

While providing therapy for a specific, relatively short period of time has always been practiced in particular types of treatments, mostly stemming from behavioural and cognitive tradition (Jongsma 2006: 83), brief approach to psychodynamic and person-centred therapies has become increasingly more popular only recently, with growing research evidence to support its effectiveness (Driessen et al. 2010; Lemma et al. 2011; Tudor 2008). There have been voices of therapists stating that 12 sessions of therapy offer a minimal time required "for a series of dynamic events to develop, flourish and be available for discussion, examination and resolution" (Mann 1973: 15) and this is the length of therapy often offered in RCTs. The field of arts therapies has also engaged in a shorter mode of treatment (Thyme et al. 2007; Thyme et al. 2009; Dokter 1996, Forrester 1996), providing both constructive criticism and appreciation for brief approach to therapy. Such approach, while limiting in terms of the

amount of client material which may be addressed, offers number of advantages, with some of them being relevant to adults suffering from depression.

Brief approach to therapy requires that the levels of symptoms are relatively low, the goals are limited and the therapist and the client(s) are focused and motivated (Bateman et al. 2010: 142). It is anticipated that the latter may present a challenge in the group of adults suffering from depression. Therefore, a special attention will be given to building participants' motivation even before the therapy has started, during initial interviews. While ideally the therapist would spend time with individual participants, in this project only the researcher will have contact with participants before the therapy - responding to potential participants' concerns and conducting initial assessments. It is understood that these contacts may have some impact on participants' motivation and the researcher will be mindful of early establishing of positive therapeutic alliance (Bateman et al. 2010: 142). She will aim to promptly and openly respond to any participants' concerns or questions. These initial contacts, if not increasing motivation, will, at the very least, aim not to decrease it. The results of initial assessment and the established therapeutic alliance will be shared with the therapist. Effective communication between the researcher and the therapist before the beginning of the therapy is thus seen as crucial and enabling the therapist to faster identify and understand participants' main problem areas and aims to work on in therapy.

The brief approach to therapy is expected to affect this project in the following aspects:

1. Therapy focuses on ego strength rather than anxieties and defences; also discourages dependence, while providing appropriate holding (Mander 2006: 07).
2. Therapist adopts a more active approach than in longer term therapy, especially at the onset of therapeutic work (Karkou, Bateman 143); structure is important in the course of therapy and in each session.
3. Communication and motivation in the research team is crucial, enabling faster identification and understanding of the main problem areas; preparation before the therapy and de-briefings after each session aim to increase improve both communication and motivation with the team.

6

2. Aims and methods

While different classifications of the levels of psychotherapy are available, in this project psychotherapy type C (Bateman et al. 2010) or of step 3 of the Cawley's classification (used in IAPT in England) will be offered. This means that work on a deeper level is expected from both the therapist and the client, whose engagement in the sessions is crucial for positive outcomes. Both art and movement psychotherapies aim to offer more than just a symptomatic relief - "reintegration and change in personality functioning, both intrapsychic and interpersonal, towards greater wholeness, maturity and fulfilment" (Bateman et al. 2010: 156).

While interventions being offered in this project are hoped to bring participants closer to finding meaning and wholeness, it is understood that overly ambitious goals will not be achievable within the scheduled timeframe. It is understood that the type of change sought in brief therapy may not be different than in longer terms therapies, but the scope is (Ghaznavi et al. 2012: 300). Therefore the offered psychotherapies will not aim to result in established changes in personality, but rather to bring the participants closer to the understanding of what changes may be beneficial to them and prepare them (by increasing confidence) to confront what has not worked well for them so far. Gaining such insight is crucial for psychodynamic psychotherapy and it is important that the client “leaves arts therapies with much more knowledge about him or herself (...) and ability to continue working toward self-discovery without the need of the arts therapies space” (Karkou & Sanderson 2006: 81). Brief therapy aims to foster this initial stage of self-discovery and, while complete rebuilding of psychic structures is not achievable during the course of therapy, tackling an area of specific difficulty will remain in focus of the sessions (Mander 2006: 83).

While it is understood that the aims for the group will be revisited and adapted, once participants’ main problems are identified, the difficulties they are likely to experience may be anticipated to some extent. These include issues commonly present within or around depression, on which more specific aims of this therapy have been constructed and will now be further discussed:

1. Instillation of hope and increase of motivation (in response to generally low motivation, to provide encouragement that recovery is possible)
2. Confidence building and realisation of own potential, development of self identity (in response to low self esteem)
3. Development of creativity and spontaneity, freedom to make decisions and experiment (in response to difficulties with making decisions and issues with control)
4. Relaxation (in response to both mental and physical tension experienced)
5. Expression of feelings, emotions, conflicts (in response to tendency to “turn inwards”, release of emotions difficult to cope with and possible transformation into creative energy)
6. Development of social support and trust, relating to others in a group, sharing of problems, experiences and insights (in response to isolation, withdrawal and difficulty with relating or sharing)
7. Development of insight and self-awareness (in response to being constricted to unhelpful defence mechanisms)
8. Awareness, recognition and appreciation of others (in response to preoccupation with oneself)
9. Discovery of universality of experience and uniqueness of individual, understanding of the effect of self on others and on relationships, rediscovery of meaning of self and the world (in response to the general search for meaning – aim which may not be achievable within brief psychotherapy process)

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Some of the above aims are common to all arts psychotherapy groups, while others seem to be of a special significance in the context of work with depression. The Survey has revealed similar therapeutic aims in the work with depression specifically, which include: generation of hope and solutions, expression of emotions, exploration of meaning behind depression, gaining of perspective, reduction of isolation.

A note should be added to aim 5: While successful therapeutic challenges may release affects and memories, which allow for further exploration and progress, defence mechanisms may and possibly should be confronted in brief therapy. However, such challenges “must be made sensitively and emphatically if they are to lessen overall defensiveness rather than to stimulate a paranoid reaction. Defence should be interpreted with respect for the underlying anxiety and impulse.” (Bateman et al. 2010: 143).

Although the themes above aim to offer a response to problems expected in depressed adults, the actual therapeutic aims for groups in this project will of course be established once individual participants’ psychological situation is known and will most likely evolve after the group work is observed in first therapy sessions. A suitable appendix to section 2 of this Manual will then be enclosed.

Specific therapeutic methods will facilitate the meeting of the above aims. In this project, the therapists will use methods and interventions corresponding to both general psychotherapeutic practice and the practice of the arts therapy of their expertise. Some of the methods to be used include:

- active listening
- paraphrasing
- mirroring (verbally / in movement)
- clarifying and interpreting (only as necessary)
- use of open questions
- accepting and withstanding silences
- responsiveness to the group’s choices and needs

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While the therapy in this project will be offered in a group setting, in arts therapies there usually is a time and space for individual engagement with arts media in the presence of others, before the group joins for sharing of art works and a verbal discussion. Groups where all participants contribute to a creation of a collaborative art piece are also offered (Liebman 2007, Malchiodi 2003). In this project both individual work and group work will be encouraged at appropriate stages of therapy and with acceptance of group participants at all times. Such stance was adopted to recognise specific problem areas present in depression. While working in a group may present a challenge to the sufferers of depression especially, the therapists will offer opportunities for individual work before progressing to group activities, once the group gains more confidence and trust is developed. It is understood that group interactions will still be visible and significant, when art work / movement is made individually in the presence of others. This presence itself may be as much as some of the participants are willing to accept, especially in the first stage of therapy. When creation of a collaborative art / movement piece

is attempted, the participants will be expected to engage actively. While this may only be possible with a certain degree of confidence and trust, group activities will not be enforced on the group by the therapist. They will, however, be offered as a choice at the later stages of the treatment.

3. Life of the group

In brief psychotherapy the time, precious and limited, may not be lost (Mander 2006: 83) and therefore each session should serve a specific purpose while the sequence of sessions needs to offer a complete course of therapy, including purposeful and well defined beginning and ending. Both stages are crucial in the therapy for depressed adults and they should allow sufficient time and space for dealing with specifically relevant to this condition issues of motivation and loss.

The whole course of therapy in this project will consist of three main stages, which will now be further discussed:

1. Beginning (2-3 sessions)

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In the brief therapy of depression successful beginning, including assessment time, seems especially important and is critical for shortening the process of therapy (Rawson 2005: 51). Attention of the therapist is crucial at all times and should initially be focused on forming positive therapeutic alliance, enabling further work (Bateman et al. 2010: 143). In this project, the mentioned process will start with the very first (e-mail) contact of each participant with the researcher and will then continue throughout the initial interview and later in the first sessions of the therapy. While different members of the research team will conduct assessment and therapy, the therapeutic alliance is expected to develop continuously and simultaneously with both the researcher and the therapist rather than separately. Therefore, special attention will be given by the researcher to passing all important information from the initial assessment onto the therapist, as participants may not consider it important to repeat themselves (Rawson 2005: 53).

During the very first therapy session the therapist will explain the formal structure of therapy, paying attention to dates and times of sessions, “setting the end from the beginning” (Rawson 2005: 57). Participants will often be reminded about the remaining time in the following sessions. The beginning of therapy will also focus on setting ground rules (serving as a therapy contract) and maintaining boundaries, to which the participants will be encouraged to contribute and discuss.

It is expected that the first sessions of therapy will facilitate aims 1-4 and will offer a safe basis for further exploration. Instillation of hope and motivation in the first session is crucial for

future attendance and it is expected that by the end of the first stage of therapy participants will know that the therapist and the researcher understand their feelings. The therapist's confidence and good will should instil the spontaneous believe in successful outcome of the therapy (Mander 2006: 84). Freedom to make decisions should be highlighted in the process of setting group rules and in the art making itself (while a wide choice of materials and media will be available). Expected tension present at the beginning of the therapy should be relieved by provision of a safe and accepting environment. (Tensions are expected to reappear throughout the process of therapy. They should, however, be relieved to the point when meaningful engagement with the group and art materials is possible.) Building of confidence will remain an aim for the whole course of therapy and it is important to address it from the very beginning. Some degree of trust in group support, feeling of safety and togetherness should be present in the group by the end of the first stage of therapy. This may be enhanced by therapist's conscious mirroring (Rawson 2005: 67) and a more active approach in facilitating, explaining and interpreting (Bateman et al. 2010: 165).

2. Main therapy (6-8 sessions)

As mentioned on many occasions before, the therapist's focus on what is happening in the group and her/his constant attention as well as ability to immediately analyse and respond to current needs of the group, would be crucial at all stages of therapy, including of course its main, middle part.

At this stage, it is important that the members of the group understand that they will need to take responsibility for their own feelings and actions in the therapy. Brief therapy does not allow enough time for "client nurturing" (Mander 2006: 91) and instead encourages independence to prevent regression. Therefore, it is expected that by this time in therapy, the participants will have realised that their feelings may be safely expressed in the therapy setting and will be accepted with no judgement. Also, the members of the group should feel that the therapist is there to support them but should have an understanding that the therapy process will require some effort and may not at all times be pleasurable.

While at this point in therapy participants should be familiar with art materials and the confidence may have grown, this may be the best time to introduce group work and attempt collaborative art making, provided that there is a common agreement for this among group members.

This stage of the therapy is considered its "peak" and it is expected that the most meaningful and possibly difficult themes will appear then, provided the group has been well prepared for this in the beginning stage. This is a time to focus on some of the underlying problems in depression – when they may be explored safely enough, with sufficient trust already developed and still enough time to end the process properly.

3. Ending (2-3 sessions)

Sufficient time and attention should be given to the last stage of therapy, when the focus shifts to the meaning and coping with the experience of loss. It is expected that the ending of the group may be a difficult time in therapy, especially for those participants, for whom grieving and loss may be an important aspect of their depression. As mentioned before, it is important that participants are aware of the end of therapy approaching and are able to locate it in time from the very beginning.

In this project ending of the therapy will include two separate but closely connected components: the last sessions of therapy itself and a final interview with the researcher. These two experiences will not be entirely different, as will both focus on reviewing aspects of treatment, but of course the group and individual session may offer unique perspectives by which the meaning of the therapy ending could possibly be enriched.

In the therapy sessions, attention will be given to acknowledgement of loss and the feelings it evokes. It is important that all group participants are offered sufficient time to explore this theme for themselves and that it is shared in a group at some point (possibly in a group work). The participants should finish therapy with a clear sense of accomplishment. While there is no expectation that the therapy will offer a lasting restructuring of personality or even remittance of specific symptoms, the process should end with a personal achievement for every participant – be it a sense of belonging, increased self esteem, experience of spontaneity or something else. The therapist will support the participants in this review process and it is likely that the group, empowered by previous experiences in the course of therapy, will offer meaningful assistance. In addition, while dependency was not encouraged at any point of therapy, the ending stage of the process should even more clearly focus on the promotion of autonomy and responsibility (Bateman et al. 2010: 143). The participants need to finish their therapy with a sense of independence, developed on the core of trust and acceptance. They are also expected to be able to make meaningful connections between their therapy and the future.

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The final interview with the researcher clinically will serve a purpose of strengthening the meaning of the review and will offer an opportunity to further explore the experience of loss, if needed. It will also offer a chance to evaluate the process of therapy and facilitate conscious decisions on what should be done next in the context of recovery.

4. Session structure and activities

The structure of the therapy seems especially important in the treatment of depressed clients, whose sense of self is most often fragile and confidence is often low (Brok 2011: 336). For such clients, beginning and closing therapy sessions in a structured manner, continued throughout the therapy, may be beneficial and desired. Structure may relieve anxiety, leading to a more

meaningful engagement with the process of therapy as opposed to preoccupation with own fears and tension. Also, the structure leads to a more meaningful use of time, with which sufferers from depression often struggle, having difficulties with making choices (Brok 2011: 336). However, it needs to be stressed that the strict structure should not affect the creative and therapeutic process. Therefore, it is important to note that in this project a general structure of each session will be provided and made known to the members, while within these specified stages of the session flexibility and opportunity to make choices will be offered to the group members at all times.

In this project, each therapy session will consist of specific components, which will now be listed. Stages 1 and 3 will take place in the sitting area of the room, while stage 2 will take place in the work area of the room, with large table shared by all participants.

1. Introduction (20 minutes)

- invitation to members to share their reflections from the previous session and/or feelings/events which felt significant between the last session and now
- group discussion on any issues concerning last session, which the members would like to address
- group discussion on the shape of current session including ideas for themes to be explored

2. Art making (20 minutes)

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- invitation to members to engage in art making (either individually or in a group)
- brief clearing up
- invitation to members to bring artwork to the group and place it on the floor

3. Conclusion (20 minutes)

- invitation to members to share thoughts and feeling about their own artwork, as well as feelings evoked by artwork created by other members
- group discussion on most prominent feelings and thoughts about the artwork itself or the process of making it

As mentioned before, the above structure concerns the formal outline of each session. However, it does not intend to limit neither the therapist nor the members of the group from implementing their own ideas and suggesting types or formats of activities. From the therapist's perspective, it is crucial to actively observe what the needs of the group may be in particular moments of therapy and to adapt approach and the shape of the session accordingly. From participants' perspective, it is important to understand that new ideas are welcomed and decisions will be made by the whole group.

Therefore, it is expected that the themes for each session will emerge from the initial discussion. It may be necessary for the therapist to take more control if it is obvious that the group struggles with making decision and more guidance may be beneficial. Such situations are expected to happen mostly in the first stage of therapy, when the therapist may need to offer more direct holding and suggest themes to be explored by the group. Any direct suggestions should always be based on group observation and not on therapist's preconceptions. Some of the themes are, however, expected to originate from the underlying problems in depression, with which the therapist should be familiar, basing knowledge on recent literature (e.g. Gotlib 2009) and the results from the Survey, which include specific list of problems likely to influence or originate from depression.

References

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- American Psychological Association, Society of Clinical Psychology (2007) Short-Term Psychodynamic Therapy for Depression (online) http://www.div12.org/PsychologicalTreatments/treatments/depression_psychodynamic.html (accessed: 2nd July 2012)
- Bateman, A., Brown, D., Pedder, J. (2010) *Introduction to psychotherapy: an outline of psychodynamic principles and practice*. New York: Routledge.
- Brok, A. J. (2011) Structured techniques to facilitate relating at various levels in group. In: Kleinberg, J.L. (ed.) *Handbook of Group Psychotherapy*. The Wiley-Blackwell.
- Dokter, D. (1996) Being together briefly: One-on-one brief dramatherapy with clients hospitalized for chronic or reactive depression. In: Gersie A. (ed.) *Dramatic approaches to brief therapy*. London: Jessica Kingsley Publishers, 188-200.
- Driessen, E., Cuijpers, P., de Maat, S., Abbass, A., de Jonghe, F., & Dekker, J. (2010). The efficacy of short-term psychodynamic psychotherapy for depression: a meta-analysis. *Clinical Psychology Review*, 30(1), 25-36.
- Forrester, A.M., Johnson, D.R. (1996) The role of dramatherapy in an extremely short-term in-patient psychiatric unit. In A. Gersie (ed.) *Dramatic approaches to brief therapy*. London England: Jessica Kingsley Publishers, 125-138.

- Freeth, R. (2007). *Humanising psychiatry and mental health care: The challenge of the person-centred approach*. Milton Keynes United Kingdom: Radcliffe Publishing.
- Gask, L., Coventry, P. (2012). Person-centred mental health care: the challenge of implementation. *Epidemiology and Psychiatric Sciences*, 21, 139-144, doi:10.1017/S2045796012000078.
- Ghaznavi, S., Witte, J.M., Levy, R.A., Roffman, J.L., (2012) Bridging Technology and Psychotherapy: Toward Investigating Psychological and Neural Correlates of Psychodynamic Psychotherapy. In: Levy R. A., Ablon J. S., Kachele H. *Psychodynamic Psychotherapy Research. Evidence-Based Practice and Practice-Based Evidence*. Springer Publications. doi: 10.1007/978-1-60761-792-1
- Gotlib, I. H., Hammen C. L. (2009) *Handbook of depression*. New York: The Guilford Press.
- Jongsma, A.E., Peterson, L.M., Bruce, T.J. (2006) Depression. In: Jongsma, A.E., Peterson, L.M., Bruce, T.J. *The complete adult psychotherapy treatment planner*, John Wiley and Sons.
- Karkou, V., Sanderson, P. (2006) *Arts Therapies: A Research-based Map of the Field*. Elsevier, Churchill Livingstone.
- Lemma, A., Target, M., & Fonagy, P. (2011). The Development of a Brief Psychodynamic Intervention (Dynamic Interpersonal Therapy) and Its Application to Depression: A Pilot Study. *Psychiatry: Interpersonal & Biological Processes*, 74(1), 41-48. doi:10.1521/psyc.2011.74.1.41
- Levkovitz, Y., Shahar, G., Native, G., Hirsfeld, E., Treves, I., Krieger, I., & Fennig, S. (2000). Group interpersonal psychotherapy for patients with major depression disorder - pilot study. *Journal Of Affective Disorders*, 60(3), 191-195.
- Liebmann, M. (2007) *Art Therapy for Groups. A handbook of themes and exercises*. Howe: Routledge.
- MacKenzie, K., & Grabovac, A. (2001). Interpersonal psychotherapy group (IPT-G) for depression. *The Journal Of Psychotherapy Practice And Research*, 10(1), 46-51.
- Malchiodi, C. A. (2003) *Handbook of art therapy*. New York: The Guilford Press.
- Mander, G. (2006) *A Psychodynamic Approach to Brief Therapy*. Sage Publications.
- Mann, J. (1973) *Time-limited Psychotherapy*. Harvard University Press.
- McDermut, W., Miller, I. W., & Brown, R. A. (2001). The efficacy of group psychotherapy for depression: A meta-analysis and review of the empirical research. *Clinical Psychology: Science And Practice*, 8(1), 98-116. doi:10.1093/clipsy/8.1.98
- National Institute for Health and Clinical Excellence (2009) Depression. The treatment and management of depression in adults. NICE clinical guideline 90. National Collaborating Centre for Mental Health.
- Rawson, P. (2005) *A Handbook of Short-Term Psychodynamic Psychotherapy*. Karnac Books.
- Ruddick, F. (2010). Person-centred mental health care: myth or reality? *Mental Health Practice*, 13(9), 24-28.

Rogers, C. (1951) *Client-centered therapy: its current practice, implications and theory*. London: Constable and Company Ltd.

Rogers, R. (1995) *On becoming a person: A therapist's view of psychotherapy*. London: Constable and Company Ltd.

Roth, A., Fonagy P. (1996) *What works for whom? A critical review of psychotherapy research*. New York: The Guildford Press.

Salvador-Carulla, L., Mezzich, J.E. (2012). Person-centred medicine and mental health. *Epidemiology and Psychiatric Sciences*, 21, 131-137, doi:10.1017/S204579601200008X.

Scottish Intercollegiate Guidelines Network (2010) *Non-pharmaceutical management of depression in adults. A national clinical guideline*. NHS Quality Improvement Scotland.

Taylor D. (2012) *Psychoanalytic and Psychodynamic Therapies for Depression: The Evidence Base*. In: Levy R. A., Ablon J. S., Kachele H. *Psychodynamic Psychotherapy Research. Evidence-Based Practice and Practice-Based Evidence*. Springer Publications. doi: 10.1007/978-1-60761-792-1

Thyme, K. E., Sundin, E. C., Stahlberg, G., Lindstrom, B., Eklof, H., Wiberg, B. (2007) The Outcome of Short-term Psychodynamic Art Therapy Compared to Short-term Psychodynamic Verbal Therapy for Depressed Women. *Psychoanalytic Psychotherapy*. 21(3), 250-264.

Thyme, K. E., Sundin, E. C., Wiberg, B., Öster, I., Åström, S., Lindh, J. (2009) Individual Brief Art Therapy Can Be Helpful for Women with Breast Cancer: a Randomized Controlled Clinical Study. *Palliative & Supportive Care*. 7(1), 87-95.

Tudor K. (2008) ed. *Brief Person-Centred Therapies. Brief Therapies Series*. London: SAGE Publications.

Yalom I.D., Leszcz M. (2005) *The theory and practice of group psychotherapy*. New York: Basic Books.

Identification of therapeutic aims - group art therapy

Main underlying problems in the group of five participants

(in order of most often mentioned)

- Difficulties forming relationships, trusting people
- Lack of self confidence
- Tiredness and/or physical pain
- Lack of motivation
- Social isolation (from either family or friends or both), turning inwards
- Loss, bereavement (also losing job and forced retirement)
- Striving to be in balance
- Sleeping problems
- Anxiety
- Anger
- Guilt, sense of failure
- Need to be in control, perfectionism
- Problems with making decisions
- Suicidal ideation or self harm
- Multiple suicide attempts
- Difficulties with acceptance of ageing process
- Eczema, stress-related

Therapeutic qualities as counterbalance to identified problems

Weight → Lightness, freedom
 Constant fighting (causes tiredness) → Relaxation, peace
 Control → Freedom
 No trust → Safety, trust
 No motivation, no future → Hope, motivation, purpose
 No or little self esteem → Self confidence, acceptance
 Struggle to keep in balance → Letting go, expression, freedom
 Blockage → Expression
 Tension → Relaxation
 Searching for meaning, purpose → Meaning, insight
 Perfectionism → Acceptance, freedom
 Anger → Expression, creative energy
 Anxiety → Trust
 Self-consciousness → Awareness of others
 Loss, bereavement → Acceptance
 Social isolation → Sharing
 Guilt → Self acceptance
 Fear of making decisions → Trust, self acceptance



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23 May 2011

Dear Ms Zubala

Ethical Approval – A descriptive and evaluative study of arts therapies practice with adults faced with depression in the UK

Thank you for your recent application to the QMU Research Ethics Panel.

Both the Panel and the Convener, Dr Jane McKenzie, have reviewed your submission, and have confirmed that they are happy to take Convener's Action to grant full ethical approval for your research.

A standard condition of this ethical approval is that you are required to notify the Panel, in advance, of any significant proposed deviation from the original protocol. Reports to the Committee are also required once the research is underway if there are any unexpected results or events that raise questions about the safety of the research. Please find the appropriate form for this enclosed.

We would like to thank you for your co-operation and wish you well with your project.

Yours sincerely

Craig Rutherford
Secretary to the Research Ethics Panel

Cc Dr Vicky Karkou, Supervisor



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24 November 2011

Dear Ania

Ethical Approval – Evaluation of arts therapies practice with adults faced with depression in the UK

Thank you for your response to the letter I sent you following consideration of your application by the Research Ethics Panel.

Dr Jane McKenzie, Convener of the Panel, has reviewed your response to the points you were required to address, and has confirmed that she is happy to take Convener's Action to grant full ethical approval for your research.

A standard condition of this ethical approval is that you are required to notify the Panel, in advance, of any significant proposed deviation from the original protocol. Reports to the Committee are also required once the research is underway if there are any unexpected results or events that raise questions about the safety of the research. Please find the appropriate form for this enclosed.

We would like to thank you for your co-operation and wish you well with your project.

Yours sincerely

Lucy Clapson
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24th July 2012

Dear Dr Andrews,

REC reference: **12/SS/0145** (previous reference: 12/SS/0102)

Study title: **A pilot clinical trial evaluating group arts therapies for alleviating symptoms of depression in adults experiencing mild to moderate depression.**

This letter is in response to your Decision of 9th July 2012, requesting amendments to my previous application for the ethical approval. The project has been given additional thoughtful consideration by myself and my Supervisors. In result and with consideration of the Research Ethics Committee's suggestions, the following changes have been made to the application:

- Comments in IRAS A6-2 and A22 have been amended to reflect the Committee's concern about sufficiency of resources and the researcher's competence to act appropriately should additional support be needed for the participants due to their deteriorating condition or in case of unsuitability for the arts therapies groups.
- Answer to IRAS A23 has been changed to include an explanation of what actions will be undertaken in case of any disclosures of a criminal nature by participants.
- Other specific concerns raised by the Committee in their Decision have been addressed (please see details below) and relevant sections of the IRAS application and the supporting documents have been amended accordingly.
- All members of the Research Team, including both Supervisors (Dr Vicky Karkou and Dr Donald MacIntyre) intend to be present during the REC meeting on the 5th September to answer any concerns.

The specific points of the Committee's Decision have been addressed as follows:

Ad 1. The start dates in the PIS have been corrected.

Ad 2. The Committee requested that possible disadvantages of taking part in this research are included in the PIS. Likelihood of emotional distress has already been mentioned in the section 'Is there any risk involved?' of the PIS from previous application. In current application, sections 'What are the possible benefits of taking part?' and 'Is there any risk involved?' have been expanded and/or amended, in consideration of the Committee's suggestion.

Ad 3. Information that the rule of confidentiality would need to be broken in case of any disclosures of a criminal nature has been included in the PIS.

Ad 4. Clarification on travel expenses has been included in the PIS.

Ad 5. Boxes for participant's initials have been added to the Consent Form and dates/version numbers added to both the Consent Form and the PIS.

Ad 6. A GP letter has now been added to the list of documents.

Ad 7. The Committee requested that details of an independent advisor be added to the PIS. This point has not been further addressed, as the relevant details (Ian McMillan, Head of School, QMU) had already been included in the PIS from previous application.

Ad 8. The Committee requested that clarification be made on how long data would be retained for and suggested there was an inconsistency of IRAS A43 with the PIS. However, IRAS A43 concerns personal data, while information in the PIS concerns research data. Both IRAS A44 and the PIS state that research data will be retained for the period of 5 years, while IRAS A43 states that personal data will be retained for 3 months and the PIS explains that it will be destroyed soon after the study is closed. Although no personal data will be stored for longer than 3 month after the study has finished, anonymised data (research data) will be safely stored for 5 years to enable any scientific validations of this research. Therefore, the researcher understands that IRAS A43 does not contradict the PIS and no changes have been made to the new application.

Ad 9. Q9 of the IRAS form has been corrected to acknowledge that this is an educational study.

Ad 10. The Committee requested that clarification be given on Independent Hospitals to be used in the study. The researcher stated in the previous application (IRAS A72) that "*Independent (private or voluntary sector) organisations*" would be the sites in the study, meaning voluntary organisations, which are expected to support the recruitment. After consideration, this has been amended in the current application, as the mentioned charities will not be the sites in the study, only being involved in recruitment process and not actually hosting the research.

Ad 11. Information about audio recording of the interviews has now been included in the PIS.

Ad 12. The suggested point has been added to the Consent Form.

I would like to take this opportunity to thank the Committee for their comments and suggestions, which enabled the improvement of the proposed research. I hope that you will consider the applied changes satisfactory. I and my Supervisors will welcome any further questions during the meeting on the 5th September 2012.

Yours sincerely,

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20th September 2012

Dear Dr Andrews,

REC reference: **12/SS/0145**

Study title: **A pilot clinical trial evaluating group arts therapies for alleviating symptoms of depression in adults experiencing mild to moderate depression.**

Thank you for your letter of 10th September 2012 and your acknowledgement of the work, which has been undertaken in preparation for the study mentioned above. This letter is in response to your provisional opinion, requesting further amendments to my application. With consideration of the Research Ethics Committee's suggestions, the Patient Information Sheet has now been amended and the specific points requiring clarification have been addressed as follows:

- Ad 1.* The layout of the PIS has been reviewed and, while it was difficult to shorten the document, effort has been made to ensure improved clarity. Section "What will happen if I decide to take part in this study?" has been further reviewed and made easier to follow with introduction of logical sub-sections.
- Ad 2.* The document is now properly titled "Patient Information Sheet".
- Ad 3.* The study dates have been revised with a more realistic start date in January 2013.
- Ad 4.* The information regarding criminal disclosure has now been made more prominent and is additionally highlighted in the PIS.

- Ad 5.* The PIS now includes additional information, explaining that an opportunity to share their experience and receive advice regarding further care will be available to the participants, once their involvement with this research is finished. Also, the PIS now explains how the results of this study may become available to the participants, if they wish.
- Ad 6.* The PIS now explains that participant's GP may be contacted if their mental or physical state deteriorates and additional care may be required.
- Ad 7.* The PIS now explains how the control group will receive arts therapy after the study is finished, but will be asked to complete questionnaires at the same times as other groups.
- Ad 8.* While IRAS A13 states that participants will be encouraged to take notes, these are understood as participants' own reflections coming from the therapy process. Such active reflection will be encouraged, as it usually is in the course of other psychotherapies, and will not be treated as research data to be analysed. Rather, participants will have a choice to either share or not their reflections with the researcher during an exit interview. If they wish to do so, they may find the notes (not necessarily verbal) helpful – as a reminder of the process and any changes and/or significant moments on the way. Any information coming from participants in the interview situation will then be recorded and retained by the researcher (becoming research data, suitable for further analysis).

Please also find the amended Patient Information Sheet enclosed for your information.

I trust that the amendments made and clarification provided strengthens the consistency of the study documents and reflects ethical requirements. I would be happy to answer any further questions regarding this research. I would also like to take this opportunity to thank the Committee for their further comments and suggestions.

With hope that you consider the applied changes satisfactory, I am looking forward to receiving your final opinion.

Yours sincerely,

Ania Zubala

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Date 21 September 2012

Ms Ania Zubala
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Dear Ms Zubala

Study title: A pilot clinical trial evaluating group arts therapies for alleviating symptoms of depression in adults experiencing mild to moderate depression.
REC reference: 12/SS/0145
Protocol number: n/a
IRAS ref no: 102184

Thank you for your letter of 20 September 2012, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites**NHS sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

The Committee has not yet been notified of the outcome of any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. We will write to you again as soon as one Research Ethics Committee has notified the outcome of a SSA. In the meantime no study procedures should be initiated at non-NHS sites.



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Chair Dr Charles J Winstanley
Interim Chief Executive Tim Davison

Lothian NHS Board is the common name of Lothian Health Board

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

- ***Amend the PIS to avoid statements such as “it is likely that you will experience the benefits of arts therapies”, and also find a way to simplify and reduce the reading in the PIS further. The Committee believe that (as it currently stands) it is very likely to result in fewer rather than sufficient people being recruited.***

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You must notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Advertisement	Version 1 - Flyer A5	18 June 2012
Advertisement	Version 1 - A4	18 June 2012
Advertisement	Version 1 - website screenshot	18 June 2012
GP/Consultant Information Sheets	Version 1	09 July 2012
Other: CV A Zubala	Version 2	02 July 2012
Other: CV Dr D MacIntyre	Version 2	02 July 2012



Other: Ethical Approval Letter from QMU		24 November 2011
Other: Intervention visual	Version 1	03 August 2012
Other: Interview schedule	Version 1	03 August 2012
Other: Research Code of Practice QMU		01 August 2011
Participant Consent Form	Version 3	25 July 2012
Participant Information Sheet	Version 4	20 September 2012
Protocol	Version 2	10 July 2012
Questionnaire: GAD - 7	Version 1	18 June 2012
Questionnaire: PHQ - 9	Version 1	18 June 2012
Questionnaire: WHO - 5		18 June 2012
REC application	Version 3	03 August 2012
Response to Request for Further Information		20 September 2012

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “*After ethical review – guidance for researchers*” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review



12/SS/0145

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Janet Andrews
Chair

Email: Sandra.Wyllie@nhslothian.scot.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments.*

"After ethical review – guidance for researchers"

Copy to: *Vassiliki (Vicky) Karkou, Queen Margaret University*

South East Scotland Research Ethics Committee 01

Attendance at Sub-Committee of the REC

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Mr Lindsay Murray	Health & Safety Manager	Yes	
Dr Kevin Smith	Biochemist	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Sandra Wyllie	Committee Co-ordinator

University Hospitals Division

Queen's Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ



CPP/SS/approval

07 August 2012

Ms Ania Zubala
Queen Margaret University
Edinburgh
EH21 6UU

Research & Development
Room E1.12
Tel: 0131 242 3330
Fax: 0131 242 3343

Email: R&DOffice@luht.scot.nhs.uk

Director: Professor David E Newby

Dear Ms Zubala

Lothian R&D Project No: 2012/P/PSY/20

Title of Research: A pilot clinical trial evaluating group arts therapies for alleviating symptoms of depression in adults experiencing mild to moderate depression

REC No: 12/SS/0145

Patient Information Sheet: Version 3
dated 25 July 2012

Consent Form: Version 3 dated 25 July 2012

Protocol: Version 2 dated 10 July 2012

I am pleased to inform you that this study has been approved for NHS Lothian and you may proceed with your research, subject to the conditions below. This letter provides Site Specific approval for NHS Lothian.

We note that an Honorary Research Contract is required for Ms Ania Zubala, who will have direct contact with patients but does not have an NHS Lothian contract. Please ensure this is in place before the Project commences.

Following a Research Ethics Committee final favourable opinion, final copies of all project documentation (with revised version numbers) should be sent, with the Research Ethics Committee letter of favourable opinion, to the R&D office. Management approval will only be valid after favourable opinion has been received.

Please note that the NHS Lothian R&D Office must be informed if there are any changes to the study such as amendments to the protocol, recruitment, funding, personnel or resource input required of NHS Lothian. This includes any changes made subsequent to management approval and prior to favourable opinion from the REC.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please inform this office when recruitment has closed and when the study has been completed.

I wish you every success with your study.

Yours sincerely

Dr Christine P Phillips
Deputy R&D Director

Cc Dr Donald MacIntyre, Chief Investigator
Paul Dearie, QA Manager



Human Resources
St John's Hospital
Howden Road West
Livingston
EH54 6PP

Telephone: 01506-523000
Fax: 01506-523417
Date: 27 February 2013

R&D Number : 2012/P/PSY/20
Rec Number : 12/SS/0145

Enquiries to: Kirsty Shields
Direct Line: 01506-523456

Ms Ania Zubala
42/2 Gardner's Crescent
Edinburgh
EH2 8DG

Dear Ms Zubala,

Title : A pilot clinical trial evaluating group arts therapies for alleviating symptoms of depression in adults experiencing mild to moderate depression

HONORARY CONTRACT

1. I am pleased to offer you an appointment as a PHD Student within NHS Lothian from 26 February 2013 until 30 April 2013.

2. Personal Property

The Division accepts no responsibility for damage to, or loss of personal property. You are, therefore, advised to take out an insurance policy to cover your personal property.

3. Confidentiality and Disclosure of Information

- 3.1. You may have access to material of a confidential or sensitive nature relating to Division business which should not be divulged to any third party during the period of your honorary contract or any time thereafter without the proper authority having first been given.
- 3.2. 'Confidential Information' shall include all information that has been specifically designated as confidential by the Division and any information that relates to the commercial and financial activities of the Division, the unauthorised disclosure of which would embarrass, harm or prejudice the Division.
- 3.3. All confidential records, documents and other papers, together with any copies or extracts thereof, made or acquired by you in the course of your honorary appointment shall be the property of the Division and must be returned to the Division on the termination of your employment.



INVESTORS
IN PEOPLE



Healthy
Working
Lives

Headquarters
Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG

Chair Dr Charles J Winstanley
Interim Chief Executive Tim Davison
Lothian NHS Board is the common name of Lothian Health Board

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use “✓” to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.....	0	1	2	3
2. Feeling down, depressed, or hopeless.....	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....	0	1	2	3
4. Feeling tired or having little energy.....	0	1	2	3
5. Poor appetite or overeating.....	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual.....	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	0	1	2	3

(For office coding: Total Score _____ = ____ + ____ + ____)

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult
at all
☐

Somewhat
difficult
☐

Very
difficult
☐

Extremely
difficult
☐

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score (<i>add your column scores</i>) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.



Psychiatric Research Unit
WHO Collaborating Centre in Mental Health

WHO (Five) Well-Being Index (1998 version)

Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better well-being.

Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a tick in the box with the number 3 in the upper right corner.

	<i>Over the last two weeks</i>	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1	I have felt cheerful and in good spirits	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
2	I have felt calm and relaxed	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
3	I have felt active and vigorous	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
4	I woke up feeling fresh and rested	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
5	My daily life has been filled with things that interest me	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0

Scoring:

The raw score is calculated by totalling the figures of the five answers. The raw score ranges from 0 to 25, 0 representing worst possible and 25 representing best possible quality of life.

To obtain a percentage score ranging from 0 to 100, the raw score is multiplied by 4. A percentage score of 0 represents worst possible, whereas a score of 100 represents best possible quality of life.

Have you been feeling **depressed**?

Nothing seems to help as much as you would like?

Would you like to try **arts therapies**?

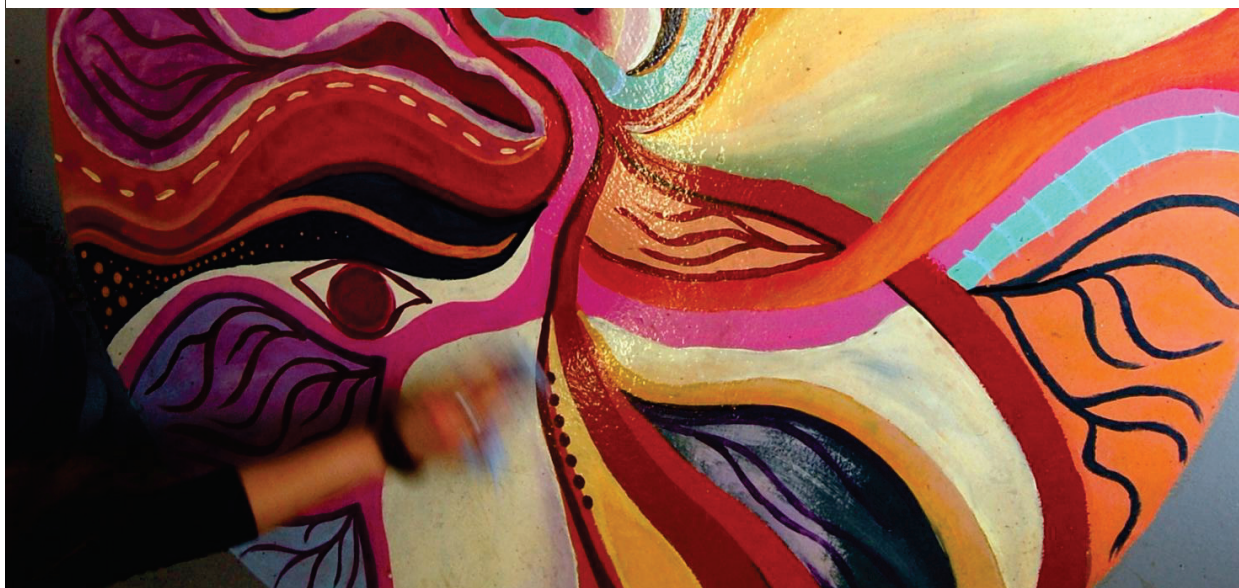
We are now looking for adults currently experiencing depression to join arts psychotherapies groups. We will be offering groups of either art or movement psychotherapy. The sessions will take place in Edinburgh (Royal Edinburgh Hospital in Morningside) for 6 weeks (meetings twice a week for one hour) and will start in the first half of February 2013. No arts skills or therapy experience is required – everyone is welcomed!

This project is a part of the research on arts therapies and depression undertaken by Ania Zubala (psychologist and PhD candidate) and supervised by Dr Vicky Karkou from the Queen Margaret University in Edinburgh. It has gained ethical approvals from QMU and the NHS. Ania will be happy to answer any questions you might have at azubala@qmu.ac.uk.

Interested?


more information on this project and arts therapies on
<http://tinyurl.com/ArtsTherapiesResearch>

to take part please email
azubala@qmu.ac.uk




Screenshot of the website with information for participants (main page).

Weblink: <http://tinyurl.com/ArtsTherapiesResearch>



Arts therapies for depression

research at the Queen Margaret University, Edinburgh




Welcome to this website!

The research aiming to explore the value of arts therapies in the treatment of depression is currently undertaken at the Queen Margaret University, Edinburgh, Scotland.

We are now looking for **adults (age 16-65), who suffer from depression**, to participate in the study, by attending arts therapies groups. The treatment will last 6 weeks with two sessions per week and will take place in a convenient location in central Edinburgh. Some groups will start in the second half of January 2012 and others in April/May 2012.

If you think you might be interested in taking part, please read the following information carefully.
If you have questions which have not been answered here, you are very welcomed to contact the researcher at azubala@qmu.ac.uk.

This research has gained the Queen Margaret University's ethical approval.



Who is doing this research?
What is this research about?
What will happen if I decide to take part in this study?
What will happen if I decide not to take part in this study?
What are the possible benefits of taking part?
Is there any risk involved?
What will happen to the results of this research study?
Will what I share in this study be kept confidential?
What should I do if I want to take part?

Interview schedule

Interviews with participants of arts therapies groups

(to be conducted by the researcher)

Areas to focus on during initial and exit interviews

Initial interview	<p>Basic information</p> <p>Current state of psychological well-being</p> <p>Identification of main problem areas and coping strategies</p> <p>Experience of arts therapies and expectations of planned therapy</p> <p>Other</p>
Exit interview	<p>Expectations and reality of therapy</p> <p>Feelings during and after the group sessions</p> <p>Current state of psychological well-being</p> <p>Any changes following the treatment</p> <p>Experience of arts therapies</p> <p>Other</p>

Interview schedule

Initial interview	
Participant	Date/time
Basic information (data mostly based on observation; questions may follow, relevant to the individual)	(might include information about: age, gender, family situation, work situation, health state/medication, interests/hobbies)
Current state of psychological well-being	If you could use just one sentence to describe yourself, what would this be?
	How do you think others may describe you?
	How do you feel on a usual day?
Identification of main problem areas and coping strategies	What is depression for you? How would you describe it?
	When have you started feeling depressed? Can you locate it in time? Can you connect it with a particular event / situation?
	Do you have any particular strategy for when you feel depressed? (Does it help?)
	How would you like to be? What would need to change for this to happen?
Experience of arts therapies and expectations of planned therapy	How do you feel about starting art / movement therapy?
	Do you have any previous experience of arts therapies / therapeutic arts?
	What expectations do you have from art / movement therapy?
Other (place for participants to ask questions they might still have)	(any other issues arising from previous questions and worth exploring further)

Interview schedule

Exit interview	
Participant	Date/time
Expectations and reality of therapy	Was art / movement therapy experience similar or different to what you expected?
Feelings during and after the group sessions	Can you recall a moment / moments during your therapy sessions which felt particularly important to you? What happened? How did that feel?
	How did you usually feel after the group sessions? Were those feelings often similar or different each time?
Current state of psychological well-being	How are you feeling now? Is this how you feel on a usual day?
Any changes following the treatment	Has anything changed in your life or yourself during the course of therapy or after it finished?
	Have there been any changes to your medication during or after arts therapy?
Experience of arts therapy	What did you like most about art / movement therapy?
	What did you not like?
	Would you like to continue this particular therapy?
	Would you recommend it to other people suffering from depression?
	Would you like to share any other thoughts / experiences from your therapy or about this project?
Other (place for participants to ask questions they might still have)	(any other issues arising from previous questions and worth exploring further)

Observational notes – Arts therapies group sessions

Type of therapy / Number of session:

Date and place:

Number of participants:

Main theme of the session description of activity, aims	
Group (ambiance, response, engagement) - at the start of the session - during the session - at the end of the session (Has anything changed? What? Direction of changes?)	
Individual participants (If significant events occurred: What happened? When? What was the outcome? Any significant changes in participants?)	
Features of artwork produced main themes, colours, forms, art materials used + art making process	
Themes arising in group discussion at the end of session	
Therapist's verbal comments regarding the session	
Reflective notes on the group process	



Queen Margaret University
EDINBURGH

Patient information sheet

Arts therapies for depression

If you are aged between 16 and 65 and are experiencing mild or moderate depression, I would like to invite you to take part in a research project which focuses on arts therapies in the treatment of depression. You should only participate if you want to. Choosing not to take part will not disadvantage you in any way. Before you decide whether to take part, it is important for you to understand why this research is being done and what it will involve. Please take your time to read the following information carefully and discuss it with others if you wish. (Information about this study is also available online at tinyurl.com/ArtsTherapiesResearch)

Who is doing this research?

My name is Ania Zubala, I am a psychologist and have trained in psychodynamic psychotherapy. I am currently working towards my PhD in arts therapies at the Queen Margaret University, Edinburgh and previously I have worked in mental health environments in Scotland. I will be happy to answer any questions you might have about this research. If there is anything that is not clear or you would simply like more information, you can e-mail me at azubala@qmu.ac.uk.

Researcher	Ania Zubala, PhD candidate
Address	Department of Nursing, Occupational Therapy and Arts Therapies School of Health Sciences, Queen Margaret University Queen Margaret University Drive, Musselburgh EH21 6UU
Website	www.qmu.ac.uk/otat/A_Zubala.htm
E-mail	azubala@qmu.ac.uk

(This research is supervised by Dr Vassiliki Karkou from the Queen Margaret University. The research team also includes another supervisor, Dr Donald MacIntyre (Royal Edinburgh Hospital). If you would like to contact an independent person, who is not directly involved in this research, but knows about it, you are welcome to contact Ian McMillan from QMU at IMcmillan@qmu.ac.uk.)

What is this research about?

This research will explore whether and how arts therapies can be helpful in the treatment of mild and moderate depression.

Patient information sheet

What are arts therapies?

Arts therapies are the forms of psychotherapy that use artistic media in the therapeutic process. Unlike in other psychotherapies, the focus is on working with arts media rather than verbally. Participants of arts therapies do not need to have specific arts skills or any other particular experience. Arts therapies in the UK consist of four disciplines: art psychotherapy, music therapy, movement psychotherapy and dramatherapy.

Why research possible treatments for depression?

Depression is a common and increasing problem in the modern world with up to 25% of people experiencing symptoms of depression at some point of their lives. The condition has an increasing social and economic impact. Each person's experience of depression is different and while there are effective treatment options available, they usually do not work for some people as well as for others. That is why it is important to explore more treatment possibilities, which might suit people who do not benefit from currently known treatments as much as they should.

Who is invited to take part in this project?

For this project, we are looking for adult participants (between 16 and 65 years old), who are currently experiencing mild or moderate depression. Please accept that, due to the requirements and limitations of this project, we will not be able to include you in this project, if your depression is severe or if you have been diagnosed with bipolar disorder.

What will happen if I decide to take part in this study?

If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. Remember that you are free to withdraw your participation at any time and without giving a reason. Participation in this research involves **attending arts therapy group** and **completing three short questionnaires** on three occasions. These will now be explained.

Arts therapies groups

If you decide to take part, you will be offered a place in a therapy group involving either art or movement and consisting of between 6 and 8 participants. Each group session will be facilitated by an experienced arts therapist. The groups will be selected randomly (by chance) and participants, who are allocated to the control group, will receive therapy after the main study is finished.

Your therapy will last for **6 weeks**, during which you will be expected to attend **1-hour (60 minutes) group sessions twice a week (12 sessions in total)**. The groups will start in February 2013, while participants in a control group will receive therapy a few months later (most likely in May 2013). Please note that we will not be able to cover travel expenses, but the sessions will take place in Edinburgh, in a location easily accessible by public transport.

Patient information sheet

Interviews and questionnaires

Before your treatment starts, you will meet the researcher and any questions you may still have will be answered. The researcher will also ask you several questions about yourself. (This conversation will be recorded using digital voice recorder; recording will be kept confidential and will only be used for the purpose of this research.) During this initial meeting, you will be asked to complete three short questionnaires about how you have been feeling recently and your general wellbeing. The questionnaires are simple to use and should take you between 10 minutes and half an hour. The whole meeting with the researcher will last for up to one hour.

Having completed the questionnaires, you will start your therapy. After the 6 week period, when your treatment is finished, you will again meet with the researcher and will be asked to fill in the same questionnaires and answer several questions. The researcher will also ask you to meet her one more time about a month or two after that to check how you are and complete the same set of questionnaires. Your involvement with the research will then be finished.

Participants in a control group will start their therapy later, most likely in May 2013. If you are in this group, you will meet with the researcher and complete the questionnaires on three occasions before starting the therapy. This means that while different groups will receive therapy at different times, all participants will be asked to complete the questionnaires at the same time.

Can I receive other treatments while taking part in this study?

Taking part in the research will not affect your rights as NHS patient or service user in any way. If you have already been receiving other forms of treatment (e.g. medication, counselling), you will continue to receive them during the course of the study. It is only advisable that you do not engage in a form of psychotherapy which is new to you while taking part in this research. You may still be offered another treatment after your involvement in this research if complete, should you feel you need it and arts therapy did not help you or not as much as you would like.

What will happen after the study is finished?

When your participation in this research is finished, you may want to share your experience with the researcher and there will be time for this in your last meeting with Ania, who will be able to offer advice if you are unsure what to do next. Once the results of this research are known, you may also want to ask the researcher to share these with you.

What will happen if I decide not to take part in this study?

Participation in this research is entirely voluntary and if you choose not to take part it will involve no loss for you of any kind. You will still be entitled to all the services you have been using and you will be offered other known treatment options as you would normally. These might include other types of psychotherapy or medication. If you are unsure of where to look for most suitable treatment, the researcher may be able to offer you some advice.

Patient information sheet

What are the possible benefits of taking part?

All arts therapies are specific forms of psychotherapy, so it is likely that by participating in this study you will benefit from your treatment, as you would from other psychotherapy. As you may know, psychotherapy is a very individual process and the effects may be different or better for some people than for others. Also, the effects of arts therapies on depression in adults have not been explored enough and therefore neither a cure from depression nor any significant positive outcome may be guaranteed. Benefits of arts therapies often reported by arts therapies' receivers include: improvement in mood, satisfaction coming from creativity, opportunity to interact with others in a non-judgemental environment and more.

By participating in this research you are contributing to a better understanding of depression and arts therapies' role in easing its symptoms, which may potentially be helpful for other people faced with experiences similar to yours, so you may feel some positive satisfaction coming from being involved.

Is there any risk involved?

As this research involves taking part in a form of psychotherapy, you are likely to experience some discomforts normally associated with such treatment. You may find that there will be moments in your therapy when something in a session will make you feel upset, worried or anxious (for example, reminding you of a painful situation or bringing up unfamiliar feelings). This does not necessary need to happen but if it does, it is a normal event and most people experience such feelings at some point of their psychotherapy. This does not necessarily mean that the treatment is not effective and is often an expected moment of transition and progress in therapy.

The questionnaires that you will be asked to complete contain some personal questions on how you have been feeling and it is possible that some of them will upset you. However, these questionnaires have been extensively used in research on depression before and most people do not find them too disturbing. While you complete the questionnaires the researcher will be available for you to ask questions, address any concerns you might have and minimise psychological distress.

Also, at the beginning of your therapy you will be reminded about the basic health and safety rules. The researcher and the therapist will ensure that your therapy space is safe and comfortable at all times.

The researcher and your therapist will do their best to assist you in any way possible prior, during and after your participation. Should you begin to feel worse during the course of the therapy or simply decide that arts therapies are not an option for you, you may withdraw from the study at any time. The researcher may then contact your GP, who will be able to offer appropriate support.

Patient information sheet

What will happen to the results of this research?

The data from this study will be used in the researcher's PhD thesis. The results will also be published in professional journals and presented at conferences. However, they will always be reported in aggregated form, so that it will not be possible to identify a single participant.

We will not be able to contact individual participants to share the outcome of the study with them, as your personal details will not be kept. However, you are invited to follow-up with the researcher (by, for example, leaving your e-mail address) to obtain a summary sheet of the key findings emerging from the study if you wish.

Will what I share in this study be kept confidential?

All information collected from you in the questionnaires and interviews will be kept confidential and will only be available to the Research Team (see page 1). All your personal details will be kept safely and only for the duration of the study (to enable contacting you) and will be destroyed immediately after the project is finished. Only anonymised data will be kept after that time. All paper documents and notes will be kept in a safe designated area at the Queen Margaret University. Anonymised data will also be stored on a secure hard drive and will be kept securely in this form for a period of 5 years. After this time all raw data will be destroyed. Also, if you withdraw from this research project at any time, all of the information that you have provided will be immediately deleted and destroyed.

In your arts therapy sessions usual confidentiality rules will apply, which means that all you do and say in the therapy room will stay there and will not be shared outside by neither of other group participants nor by the therapist. You may choose to share some of your personal experiences or thoughts with the researcher after your therapy is finished, but this is entirely voluntary and you will not be expected to do so.

Please note: Confidentiality may not always be assured when disclosure of a serious criminal nature is made. Also, should your mental or physical health deteriorate significantly during the course of this research, the researcher may need to let your GP know. However, no personal information you give in the therapy will ever be shared.

What should I do if I want to take part?

If you have read and understood this information sheet, any questions you had have been answered and you would like to be a participant in this study, please now see the consent form. You may contact Ania (the researcher) at any time at azubala@qmu.ac.uk.

Thank you for reading this information sheet.



Queen Margaret University
EDINBURGH

Consent Form

Arts Therapies for Depression

please initial box

1. I confirm that I have read and understood the information sheet for the study on Arts Therapies and Depression and I have had an opportunity to ask questions.
2. I understand that my participation is voluntary and that I have the right to withdraw at any time, without giving any reason and to refuse to answer any particular question.
3. I agree that interviews with the Researcher will be recorded (only voice recordings will be taken).
4. I agree that my data gathered in this study will be stored securely and I understand that all details about me will remain strictly confidential and only accessible to the Research Team.
5. I understand that the results from this study may be published in professional journals and presented at conferences, with all the data being anonymised.
6. I give permission for my GP to be informed of my participation in this research and given any relevant information.
7. I understand that I can keep a copy of this information pack for my records.
8. I agree to the Research Team having the following personal details for the purpose of contacting me directly to arrange introductory and final meetings.
9. I understand that relevant sections of data collected during the study may be looked at by the Research Team, individuals from the Sponsor, regulatory authorities or from the NHS organisation, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.
10. I agree to take part in this study.

Name of Participant

Participant's contact details (e-mail or telephone)

Participants's GP contact details

Date

Participant's signature

Name of Researcher

Date

Researcher's signature

Thank you for agreeing to participate in this research.



Queen Margaret University
EDINBURGH

Ania Zubala

PhD candidate in Arts Therapies
School of Health Sciences
Queen Margaret University
azubala@qmu.ac.uk

[Date]

Dr *[Doctor's name]*

[Address of GP Surgery]

Dear Dr *[Doctor's name]*

Re: *[Patient's name]*

I am a PhD candidate, currently undertaking research in the field of arts therapies. My PhD project aims to describe and evaluate arts therapies practice for mild to moderate adult depression and it involves a pilot clinical trial, which will assess participants' response to arts therapies in comparison to routine treatment (either medication or psychological therapies or both).

Your patient, *[Patient's name]*, agreed to take part in the trial and was randomised to receive 12 group *[art psychotherapy / movement psychotherapy]* sessions to be provided over *[October-November 2012 / February-March 2013]*. In addition to group arts psychotherapy sessions, *[Patient name's]* participation in this study will involve completion of several questionnaires and attendance of interviews.

If you would like any further information about this project, you are very welcomed to visit the study's website: <http://tinyurl.com/ArtsTherapiesResearch>. Please also do not hesitate to contact me with any further questions using the details above.

Yours sincerely,

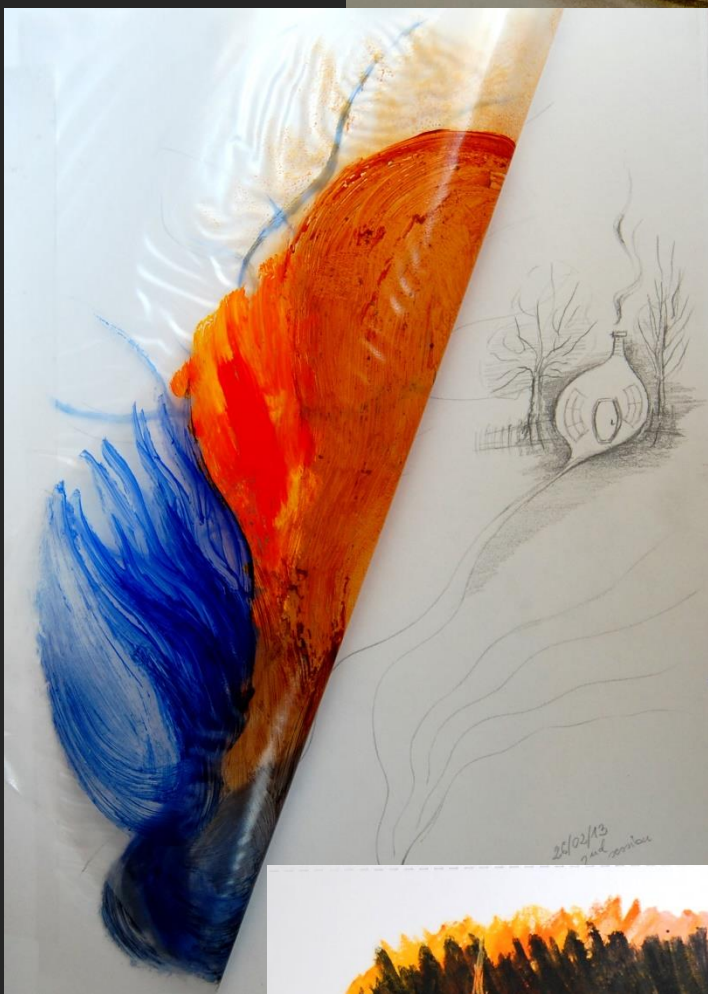
Ania Zubala

session	background	observation	reflection
S5	<p>Participants encouraged to look at their artwork and comment on changes, insights</p> <p>Therapist shared themes that she noticed: balance, anxiety, calmness, travel, decision making, guilt, growth, loneliness</p> <p>One P. comments on growing confidence (noticed in use of art materials and space)</p> <p>Theme: confidence</p>	<p>Confidence</p> <p>Small steps on the journey towards confidence (steps slowly becoming bolder, more defined)</p> <p>Confidence is changeable (present on one day, absent on another – it's not given, it comes and goes; changes from rain to sun – it's good to have tools to help through the rain)</p> <p>Someone "froze" when heard about the theme but decided to try anyway</p> <p>Someone found working with theme more meaningful ("If not given a theme, I would only attempt to paint nice pictures, I will not want to touch the emotions or problems")</p>	<p>Working with a theme brings both: relief and disappointment (anxiety slightly relieved and some problems may be touched, while others (possibly more important?) are blocked; depth is lacking)</p> <p>Energy and humour lost from the group</p> <p>Group willingness to engage in more in-depth work, to share and express emotions, but strong fear and still hiding away -> a trigger is needed to release these emotions and truth, honesty? (now lost, after first 2-3 sessions)</p> <p>One step forward, two steps backwards (or two steps forward, one step backwards?)</p> <p>Need to relieve tension? - when relaxation is achieved more meaningful work may be done?</p>
S6	<p>Invitation to reflect on last session and identify a theme to work with</p> <p>Theme of spring emerging (ideas: spring, changes, waking up, light)</p> <p>Theme: spring</p>	<p>Artwork picturing new life, growth. However, a winter sky around it.</p> <p>Attempt to depict movement, something emerging, different layers, changes</p> <p>Similarities in two artworks: well-defined centre with lighter middle and darkness around – layers, intertwined</p> <p>Movement noticed in another P's artwork (to which P agrees, saying that movement was on her/his mind while making artwork)</p> <p>Someone comments on calmness and wavy qualities, to which author responds: "calmness and turmoil amongst it"</p> <p>Attention turns to P., who chose dark colours. Group then notices different shades and textures, makes association to mood and emotions. Also, growing plants underneath the darkness ("they come out whether you like it or not" – light will come despite the turmoil and darkness) P. stays with image silently.</p> <p>Sun, that allows to sleep better and wake up fresher (waking up)</p>	<p>Confidence in the group growing (participants asking whether they may share materials, use unopened materials, exploring new art media)</p> <p>New qualities in participants emerging (qualities different than usual for all: turning inwards, openness and dialogue, facing real emotions, gentleness, confidence)</p> <p>Waking up/ Light/ Ambivalence/ Energy/ Changes/ Growth</p> <p>New energy appears in group comments (literally) – participants speak about waking up, energy, hope.</p> <p>Participants notice that energy is present in every image ("they all have it") – recognition of common themes in artwork, sharing, dialoguing.</p> <p>Ambivalence in artwork – light and colours layered with winter, darkness (there is a winter component in spring)</p> <p>Mandala appears in artwork of two participants</p>



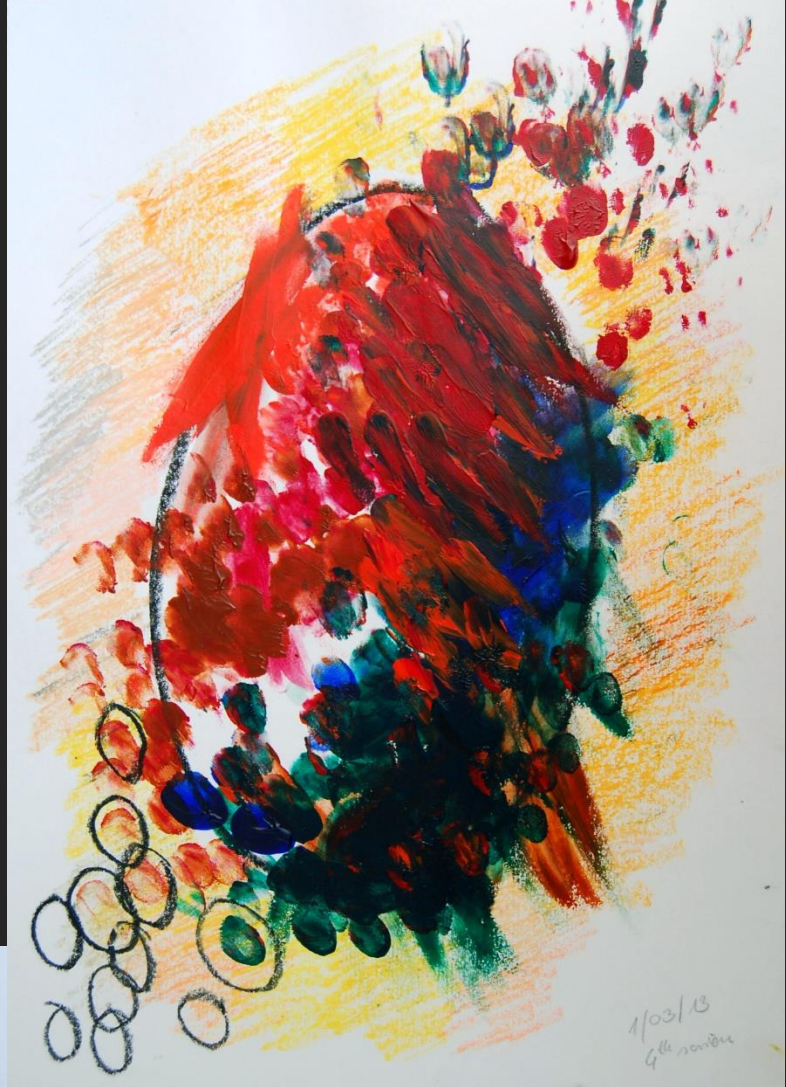
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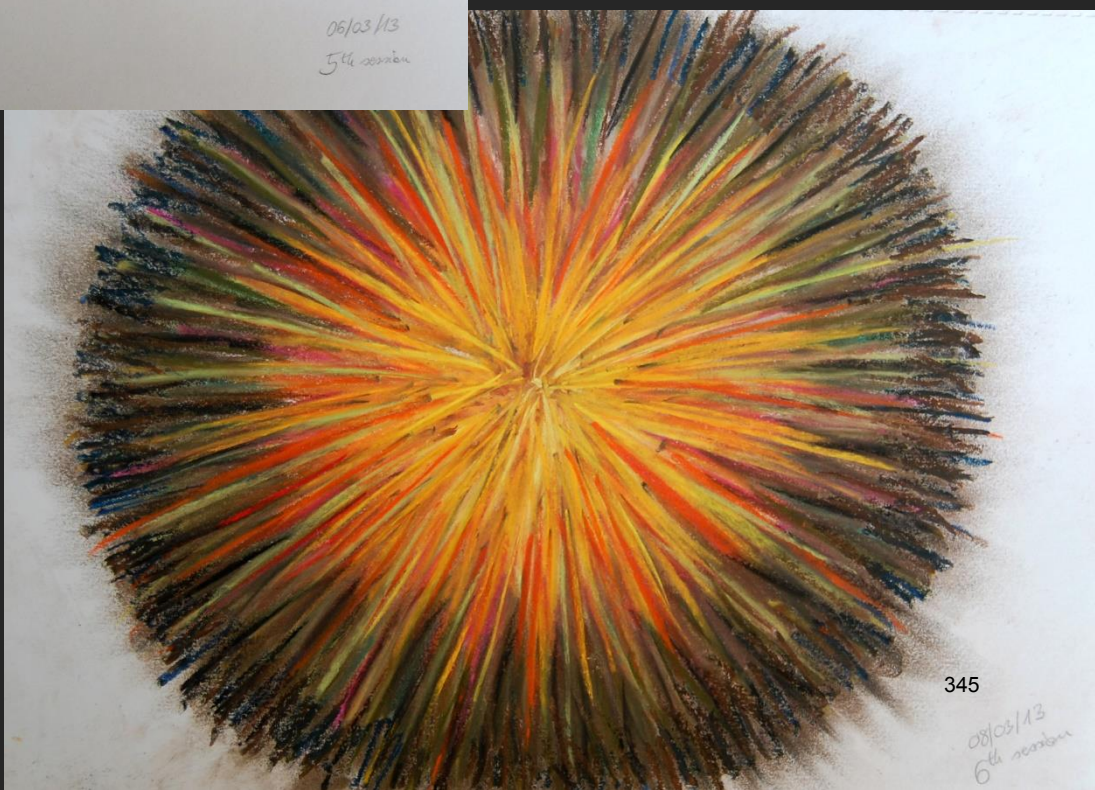




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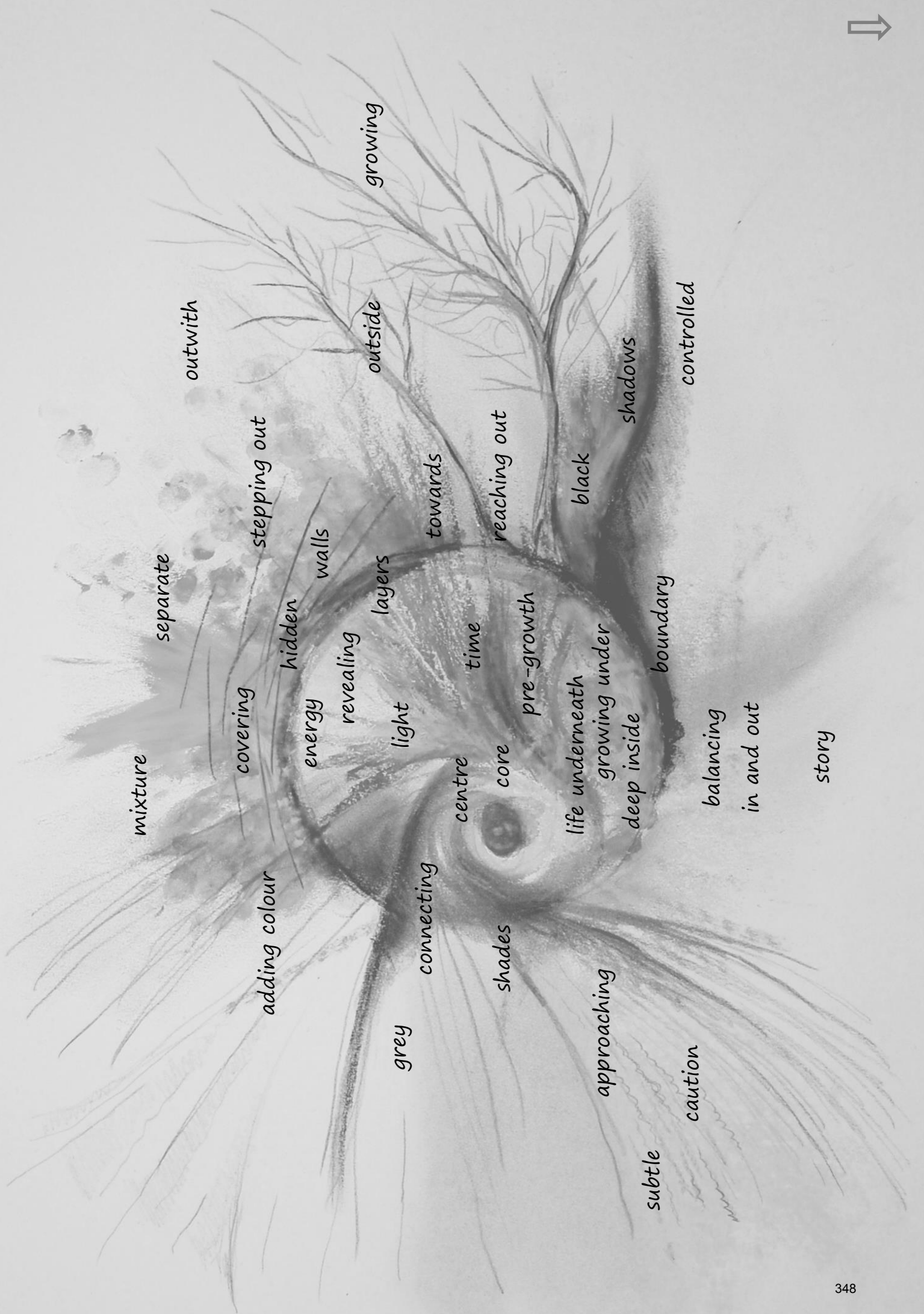


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mixture

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outwith

covering

stepping out

hidden

walls

energy

revealing

layers

light

towards

outside

growing

centre

time

core

pre-growth

reaching out

life underneath

growing under

deep inside

black

shadows

controlled

boundary

balancing

in and out

story

adding colour

grey

connecting

shades

approaching

subtle

caution



Contents lists available at ScienceDirect

The Arts in Psychotherapy



Description of arts therapies practice with adults suffering from depression in the UK: Quantitative results from the nationwide survey

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ABSTRACT

There is growing evidence that arts therapies may be under-used treatments for the 'global burden' of depression. However, the experiences of arts therapists, their methods, tools and ways of working with this client group remain unclear. Arts therapies in the UK are a form of psychotherapy. They use arts media alongside therapeutic relationship as means of therapeutic change and include four disciplines: Art Therapy (AT), Music Therapy (MT), Dance Movement Psychotherapy (DMP) and Drama Therapy (DT). In 2011, all arts therapists registered in the UK were invited to complete an online questionnaire concerning their practice in general and specifically in relation to clients with depression. The Arts Therapies Survey received 395 responses. Arts therapists who work primarily with depression were identified and compared to those who do not work with depression on a range of factors, including preferred theoretical approaches and style of working. Arts therapists who specialise in depression tend to follow Psychodynamic principles more often, are more likely to be older and experienced, work with groups, in health settings and with adults more often than children or adolescents. These quantitative findings enable the description of most common practice of arts therapies with depression in the UK and are intended to serve as a reference for arts therapists themselves and other professionals interested in the treatment of depression. Qualitative data gathered in the survey will be presented in a separate paper, with the aim of deepening the understanding already gained.

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Introduction

Depression is a broad and heterogeneous diagnosis (NICE guideline 90, 2009a, 2009b) and a "multifactorial illness" (SIGN guideline 14, 2010) with often complex aetiology, characterised by biological, social and psychological factors. The effects of this condition are damaging to the person as a whole involving body, affect, and cognitive processes. Depression not only seriously affects individuals' wellbeing but is also a 'global burden' (Scott & Dickey, 2003; WHO, 2012). By the year 2020 it is predicted to become the second most disabling illness in the world after ischaemic heart disease.

As treatment options commonly available in the UK (antidepressant medication, psychosocial and psychological interventions) present specific disadvantages and are not suitable for all depres-

sion sufferers, other treatments are worth investigating, and arts therapies may represent a better option. By considering non-verbal communication in the therapeutic process arts therapies may offer a valuable alternative to talking therapies especially for those, who may find it difficult or impossible to engage on a verbal level.

In the last decade, arts therapists worldwide have acknowledged the importance of research for the field, and Cochrane systematic reviews for depression have been undertaken in the disciplines of music therapy and dance movement therapy (Maratos, Gold, Wang, & Crawford, 2008; Meekums, Karkou, & Nelson, 2012). Nevertheless, more effectiveness studies of high quality (Evans, 2003) are required from other arts therapies disciplines, if arts therapies are to take their place amongst more conventional treatments.

However, any truly meaningful evidence needs to be based on a deep understanding of the intervention examined and arts therapies practice with depression has not yet been comprehensively described and explained. Although there is anecdotal evidence that arts therapists work extensively with adults affected by depression, their experiences, methods, tools and ways of working with this client group remain unclear to themselves and unknown to many health professionals.

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A map of the field of arts therapies in the UK has been presented by Karkou and Sanderson (2006) and there are publications available (Cattanach, 1999; Payne, 1996), which indicate the patterns of practice of arts therapists in case studies of group work or individual clients' treatment. However, apart from several rather older and more general studies (e.g. Reynolds, Lim, & Prior, 2008 and Liebmann, 2007 on Art Therapy; Blatt, 1996 on Dance Movement Therapy; Emunah, 1994 and Dokter, 1996 on Drama Therapy; Odell, 1988 on Music Therapy), little can be found in the literature on how arts therapists work with clients suffering from depression in the UK, and the specifics of treatment of this particular group. There is therefore, a need for a timely review of the state of arts therapies for depression in the UK.

Aims of this research

This research as a whole employs mixed methodology and aims to describe and evaluate arts therapies for adult depression. The descriptive phase (of which quantitative results are presented in this paper) is concerned with providing an account of how arts therapists work with people suffering from depression and identifying patterns emerging from their practice. More specifically, in the first part of the Arts Therapies Survey, the following research questions have been addressed:

- Do arts therapists work with depression? What is the extent of this work?
- What theoretical backgrounds determine arts therapists' practice with depression?
- What are the characteristics of the therapists who work with depression? Do they differ from the characteristics of those, who do not work with depression?
- Does the practice of arts therapists, who work with depression, differ from the practice of those, who do not work with depression? If so, in which area(s)?

Ethical approval

This research received an ethical approval from Queen Margaret University, Edinburgh, in May 2011.

Method: Survey

A nationwide online Arts Therapies Survey interested in practical and professional aspects of arts therapies practice, including theoretical principles, aims, methodology and evaluation, was launched in June 2011 and closed in September 2011. Responses were coming from arts therapists of all four disciplines recognised in the UK.

The questionnaire was developed by Karkou and Sanderson (2006) and revised in 2009. It consisted of multiple choice, single choice and open type questions, concerning: general information about practice (8 items), theoretical influences (2 items), assessment and evaluation (4 items) and biographical information (6 items). Items concerning theoretical principles (37 in total) were grouped in six factors (labelled: Humanistic, Psychoanalytic/Psychodynamic, Developmental, Artistic/Creative, Active/Directive, Eclectic/Integrative). Between five and seven statements were allocated to each theoretical principle (factor) and required respondents to indicate their agreement or disagreement on a scale of 1–5.

The questionnaire was adapted to the purpose of this research in 2011 to include three additional items aiming to identify respondents who worked with depression. Also, an online version of the questionnaire was developed for the purpose of this study using

Bristol Online Surveys system. To ensure the quality of the questionnaire after those changes (additional items and new mode of delivery), it was firstly evaluated in a pilot among arts therapists at Queen Margaret University. All of the participants ($N=29$) accepted the online mode of delivery with a majority clearly preferring this to the traditional paper mode. The structure, content and presentation of this questionnaire were generally positively evaluated. Respondents also provided other positive feedback including comments on the valuable opportunity to take time to think about their practice.

Online delivery of this survey was chosen for number of reasons, including cost, need of Associations' assistance in distribution and willingness for making good use of technology for scientific purposes, wherever this enhances the delivery of the project.

Participants

The study included arts therapists who were qualified to practise within the UK (having completed relevant training at postgraduate level, either in the UK or overseas) and/or who had acquired licence to practise as arts therapists from the relevant professional associations (British Association of Art Therapists, Association for Dance Movement Psychotherapy UK, British Association for Music Therapy or The British Association of Dramatherapists).

The survey was intended to reach all arts therapists registered in the UK (estimated number in 2010: 3000, according to Health Professions Council's statistics). As personal details of arts therapists could not be made available to the researcher, support for this study was sought from Arts Therapies Professional Associations. All four Associations offered their help with advertising of the survey (via newsletters, e-Bulletins and members' areas on the websites). Other relevant associations, networking groups, clinical and educational settings were also contacted. One invitation to take part and one reminder were sent to the Associations before the survey closed.

An option to be informed about the results of this survey was given to the respondents and those who agreed to be contacted and provided their email addresses will receive updates on any publications.

Trustworthiness

The survey used a questionnaire that had been previously devised and checked for its validity and reliability (Karkou, 1998). Factor analysis revealed that each of the six factors presented acceptable internal consistency (alpha ranging from 0.56 to 0.71) and could be utilised as a valuable tool for description of complex aspects of arts therapists' practice. Conducting the pilot of the online survey ensured that this new mode of delivery was very well received by the therapists and that the new items were easily understandable and their meanings were clear.

In addition, while the researcher had relatively little control over the recruitment process, the highly suitable quality of the sample had been ensured. Contacts through professional Associations and other respected and trusted networking groups ensured that only qualified and registered practitioners had been invited to take part.

Quantitative data analysis was conducted using SPSS19 software for descriptive and inferential statistics (IBM, 2012).

Results

Arts therapists of all disciplines recognised in the UK took part in the survey, a total number of 395. Art therapists/psychotherapists formed the largest group ($n=243$, 62% of the total $N=395$) followed by dramatherapists ($n=59$, 15%), music therapists ($n=50$, 13%) and dance movement psychotherapists as the smallest group ($n=36$,

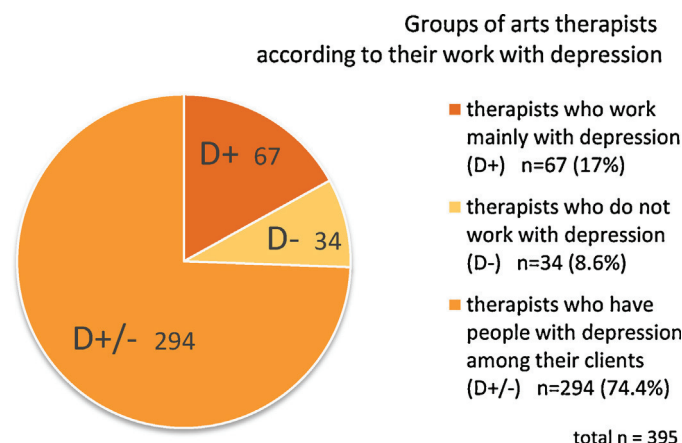


Fig. 1. Groups of arts therapists, according to frequency and/or intensity of work with depression.

9%). According to the Health & Care Professions Council (HCPC, 2011) and ADMP UK, art psychotherapists form the largest group (AT = 52%) amongst the total number of arts therapists in the UK, followed by music therapists (MT = 23%), dramatherapists (DT = 18%) and dance movement psychotherapists (DMP = 7%). Results showed that while the proportion of ATs and MTs within the sample and within the total population of arts therapists was statistically different (95% confidence interval; ATs: $z = 2.8$, MTs: $z = 2.0$), DTs and DMPs were similarly represented. Therefore, results and conclusions offered for ATs, DTs and DMPs in this paper might represent reasonably those that could be expected from the total population of arts therapists whereas those for MTs who were underrepresented, should be interpreted with more caution.

The sample consisted of 84% female and 16% male respondents. According to HCPC (2011) statistics, the total percentage of female arts therapists (ATs + MTs + DTs) is 83%, and male arts therapists, 17%. Dance movement psychotherapists were not part of the HCPC in 2011 and not represented in these statistics, however, and even stronger predominance of females is presumed for this speciality group. With regards to gender, this sample can therefore be treated as representative for the whole population of arts therapists in the UK.

For the purpose of this study, the questionnaire included two specific items to allow for identification of three exclusive groups of arts therapists (see Fig. 1): those, who work primarily with depression (group D+), those, who do not work with depression (group D-) and those, who have people with depression among their clients, but do not consider them to be their main client group (D±). In the analysed sample, group D± was the largest, with 74% of the rapists meeting the criteria. Further 17% of arts therapists declared

that they worked mainly with depression (D+, $n = 67$), while only 9% stated that they did not encounter depression in their practice (D-, $n = 34$). More generally, over 91% of arts therapists ($n = 361$) stated that there were people suffering from depression among their clients.

In order to increase understanding of how arts therapists work with depression, the described groups were compared on various factors, derived from the questionnaire.

Biographical information of arts therapists (sex, age, experience)

The proportion of female to male therapists was roughly the same in all three groups of respondents, while age of therapists differed between groups (see Fig. 2). Nearly 30% of arts therapists in group D- were under 30 years old, while only under 5% of the rapists from group D+ belonged to this age group (in group D± this figure was nearly 7%). The difference between groups D+ and D- is statistically significant.

Also, respondents in group D- reported fewer years of experience than in group D+; 50% of therapists in group D- claimed that they had less than three years experience in comparison to 19% in group D+ (and exactly the same, 19%, in group D±). These findings seem consistent with the common notion that the amount of experience naturally increases with age.

Arts therapists' style of working (work environment, group vs individual work, work alone vs in a team)

Therapists in all groups stated that they worked on their own as well as in a team with other professionals equally often, and both styles of working were reported by between 47% and 66% of the rapists, regardless of whether they work with depression or not. In addition, between 27% and 33% of therapists in all groups work in a team with other arts therapists (proportions were not statistically different). Working alone or in a team with other professionals seemed to be equally prevalent styles within arts therapies practice, while working with other arts therapists was reported to be fairly often present but a less common practice.

In contrast, therapists' answers to the question about main working environment differed largely, depending on whether they worked with depression or not. Arts therapists in group D+ reported that health service was their main working environment most often (55%), while only under 12% of therapists in group D- chose this option (difference significant, $z = 5.2$). On the contrary, 32% of the rapists from group D- and only under 8% from group D+ worked within educational setting (difference significant, $z = 2.8$). No significant differences between groups D+ and D- were found in relation to working in voluntary sector, social services or private practice. Responses of therapists from group D± may be placed somewhere

Biographical information of arts therapists		D+	D-	D+/-	z value (D+ : D-)
sex	F	88.1%	85.3%	83.0%	
	M	11.9%	14.7%	17.0%	
age	< 30	4.5%**	29.4%**	6.8%** D-	$z = 2.9888$
	31-40	19.4%	23.5%	23.5%	
	41-50	34.3%	14.7%	28.9%	
	51-60	28.4%	20.6%	31.3%	
	> 60	13.4%	11.8%	9.5%	
	> 60	13.4%	11.8%	9.5%	
years of experience	< 3	19.4%**	50.0%**	19.0%** D-	$z = 3.0685$
	4-7	20.9%	8.8%	15.0%	
	8-11	22.4%	11.8%	16.7%	
	12-15	4.5%	8.8%	14.3%	
	> 15	32.8%	20.6%	35%	
	> 15	32.8%	20.6%	35%	

Fig. 2. Biographical information of arts therapists in three groups (highlighted areas of statistically significant difference: (**)) at 99% confidence interval; based on z-test).

Arts therapists' style of working		D+	D-	D+/-
lone and/or team work	on my own	65.7%	61.8%	54.2%
	team -with other arts therapists	26.9%	26.5%	33.2%
	team -with other professionals	58.2%	47.1%	59.7%
	Other	2.9%	5.9%	7.5%
main working environment	health service	55.2%**	11.8%**	54.1%** ^{D-}
	educational setting	7.5%**	32.4%**	13.9%** ^{D-}
	private practice	17.9%	23.5%	11.2%
	voluntary agency	10.4%	14.7%	7.5%
	social service	3.0%	5.9%	7.1%
	other	6.0%	11.8 %	6.1%
age range of clients	children <11	17.9%**	61.8%**	44.4%** ^{D+}
	adolescents 11-16	28.4%**	55.9%**	40.0%
	young adults 17-25	52.2%	32.4%*	52.2%** ^{D-}
	adults 26-65	80.6%**	47.1%**	70.8%** ^{D-}
	older people >65	28.4%**	5.9%**	25.8%** ^{D-}
one-to-one and/or group work	one-to-one	85.1%	85.3%	82.4%
	families/couples/dyads	20.9%	23.5%	23.1%
	groups	71.6%*	50.0%*	68.5%** ^{D-}

Fig. 3. Arts therapists' style of working in three groups of respondents (highlighted areas of statistically significant difference: (*) at 95% confidence interval, (**) at 99% confidence interval; based on z-test).

in between (54% work in health service, 14% in educational setting) but closer to group D+ (no significant differences between D± and D+) than D– (differences between D± and D– statistically significant, see Fig. 3 for details).

This finding seems to be somehow related to the age of clients with whom therapists worked. Most therapists in group D–, not surprisingly, while working in educational setting stated that their clients were children (62%) and adolescents (56%). They worked with young adults (32%) and adults (47%) less often and very rarely worked with older people (6%). Exactly the opposite was true for group D+, where therapists much more often worked with adults (80%) and young adults (52%) than with children (18%) or adolescents (28%). This last group also worked with older people relatively often (28%). Differences between groups D+ and D– are statistically significant at 99% confidence interval in most cases (see Fig. 3 for details). Group D± is again in the middle, with less defined differences between the frequency of working with different age groups. However, adults and young adults remained the main client group (significant difference in relation to group D–), with work with children and adolescents happening often (significant difference in relation to group D+) and work with older people being the least common (again, differently to group D–).

Therapists in all three groups agreed that they worked with individual clients most often (between 82% and 85%), while work with families or couples was the least common (between 21% and 24%). However, work with groups was reported by 72% of therapists in group D+ and only 50% therapists in group D– (difference significant, $z=2.1$), with group D± being again in between, but much closer to group D+ (69%, significant difference in relation to group D–, $z=2.0$).

Arts therapies disciplines in three groups of arts therapists

Arts therapists of various disciplines were represented in the three groups in different proportions, with group D± being most similar to the total sample (see Fig. 1 for reference). Groups D+ and D–, however, differed significantly, with art therapists (ATs) being overrepresented in group D+ (73%) and underrepresented in group D– (47%) in relation to the total sample (62%). The presence of ATs in groups D+ and D– was statistically significantly different at 95% confidence interval ($z=2.5$), as it was in groups D+ and D± ($z=2.1$). Dramatherapists (DTs), on the other hand, were better represented in group D+ (19%) than in any other group, including

the total sample (result not statistically significant), while music therapists (MTs) were significantly underrepresented in group D+ (under 2%) in comparison to their presence in other groups, including total sample, which varied between 13% and 15% (significant difference at 95% confidence interval and $z=2.1$ between groups D+ and D–, at 99% confidence interval and $z=5.3$ between D+ and D±). While proportion of dance movement therapists (DMPs) in group D± (nearly 9%) was nearly the same as in the total sample (just over 9%), it was lower in group D+ (nearly 5%) and much higher in group D– (just over 20%). The difference between DMPs presence in groups D+ and D– was statistically significant at 95% confidence interval ($z=2.2$).

For clarity and increased understanding, the same data has also been looked at from a different perspective. Fig. 4 illustrates the percentage of therapists from different groups (D+, D– and D±) within each of arts therapies disciplines. This suggests that working with depression specifically was relatively more common among art therapists and dramatherapists (20% and 22% of total sample, respectively) than it was among music and dance movement therapists (2% and 8% of total sample, respectively). The difference was statistically significant (at either 95% or 99% confidence interval) between ATs and MTs ($z=5.5$), ATs and DMPs ($z=2.3$), DTs and MTs ($z=3.5$) and DTs and DMPs ($z=2.0$), while it was not significant between ATs-DTs and MTs-DMPs.

Moreover, other differences between groups of therapists seem apparent. While particularly low percentage of music therapists worked with depression specifically (2%), they still worked with clients who have symptoms of depression (88%) very often. In comparison, dance movement therapists seemed to be the group working with non-depressed clients most often (20% of DMPs) in relation to other disciplines (between 7% and 10% among ATs, MTs and DTs). The difference in the frequency of working with

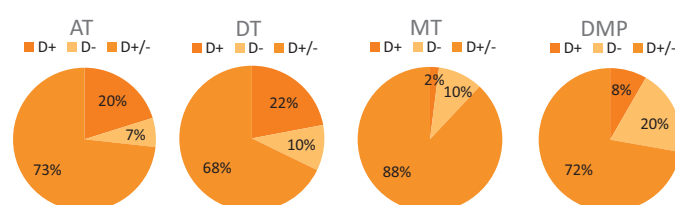


Fig. 4. Percentage of arts therapists from different groups (D+, D– and D±) within each of arts therapies disciplines.

Theoretical factors	N	Mean	Std. Deviation	Std. Error Mean
Humanistic	group D+	66	2.0238	.54244
	group D-	34	2.0672	.47215
Psychoanalytic*	group D+	66	2.0811	.60390
	group D-	34	2.3529	.67321
Developmental	group D+	66	2.3409	.75304
	group D-	34	2.2088	.62686
Artistic/Creative	group D+	66	2.4465	.50866
	group D-	34	2.6618	.60648
Active/Directive	group D+	66	2.8355	.86960
	group D-	34	2.8035	.74813
Eclectic/Integrative	group D+	66	2.1545	.60744
	group D-	34	2.0974	.68777

Fig. 5. Comparison of two groups of arts therapists (D+ and D–) in relation to factors (significant difference highlighted, $p = 0.043$).

non-depressed clients between ATs and DMPs was statistically significant at 90% confidence interval ($z = 1.9$).

It should be noted that since the sample might not be representative of the total population of music therapists (see Limitations), the preceding results need to be considered with caution.

Severity of depression as reported by arts therapists

Therapists who had stated that there were depressed people among their clients (groups D+ and D±), were also asked to estimate the severity of majority of their clients' condition. Arts therapists, who considered themselves to have specialised in working with depression (group D+), tended to respond that their clients' condition was severe more often than those who worked with depression alongside other conditions (group D±). In group D+, nearly 60% of respondents described the depression of majority of their clients as severe, 37% as moderate and only 3% as mild. For comparison, nearly 50% of the therapists in group D± described their clients' condition as moderate, 40% as severe and 10% as mild. The difference between two groups was statistically significant at 95% confidence interval in all levels of the severity of depression: severe ($z = 3.0$), moderate ($z = 2.0$) and mild ($z = 2.6$).

Preferences for particular theoretical approaches in two groups of arts therapists

Two groups of arts therapists (D+, $n = 66^2$ and D–, $n = 34$) were compared to determine whether there was a difference between them (and if so, in what direction) in relation to preference for specific theoretical approaches (six factors identified by Karkou, 1998). Results revealed that preferences for theoretical approaches differed between groups.

Arts therapists in group D+ agreed more strongly than arts therapists in group D– with the following theoretical principles: Humanistic, Psychoanalytic and Artistic/Creative. Arts therapists in group D– agreed more strongly than those in group D+ on other principles, that is: Developmental, Eclectic/Integrative and Active/Directive. An independent samples t -test was conducted to examine whether there was a significant difference between the two groups of arts therapists in relation to their preferred theoretical approaches (see Fig. 5). The test revealed a statistically significant difference between group D+ and group D– in relation to Psychoanalytic factor ($t = -2.1$, $df = 98$, $p < 0.05$). Arts therapists, who worked mainly with depression (D+, $M = 2.1$, $SD = 0.6$) agreed more strongly with Psychoanalytic principles than arts therapists, who did not work with depression (D–, $M = 2.4$, $SD = 0.7$).³

² Responses of one of the therapists in group D+ were excluded from the analysis, as over 50% of data was missing and therefore $n = 66$ rather than 67 as in initial dataset.

³ Note that lower means indicate higher level of agreement, on a 5 point scale, where 1 = strongly agree and 5 = strongly disagree.

Other theoretical influences in two groups of arts therapists

The two groups of arts therapists (D+ and D–) were also compared on other self-reported theoretical influences (see Fig. 6). Data appeared to indicate similarities in both groups, with strongest influences (reported by at least 40% of respondents) in 'Psychodynamic theory', 'Attachment theory', 'Work of Winnicott', 'Specific arts therapies tradition', 'Object relation theory' and 'Developmental theories'. The least popular influences (chosen by less than 10% respondents) included: 'Gestalt', 'Transactional analysis theory' and 'Kelly's personal construct'.

Statistical analysis was performed to determine whether groups D+ and D– differ in their self-reported theoretical influences. The Pearson Chi-Square test confirmed that arts therapists in group D– regard Play therapy as one of their theoretical influences statistically more often than therapists in group D+ ($p < 0.05$). In addition, analysis of proportions revealed statistically significant differences between groups at 95% confidence interval in Play therapy ($z = 2.3$) and two other influences: Specific artistic tradition ($z = 2.1$) and Kelly's Personal Construct theory ($z = 2.0$).

Overall, while certain theoretical influences were more popular among arts therapists in general, they seemed not to significantly differentiate between those therapists who worked mostly with depression and those who did not.

Limitations

Exact number of arts therapists who received invitation to the survey cannot be known and although efforts were made to reach all arts therapists practicing in the UK, the actual number of potential participants contacted is most likely significantly smaller. Cook, Heath, and Thompson (2000, p. 833) suggest that number of pre-contacts and reminders are the factors associated with higher response rate in online surveys, while Kaplowitz, Hadlock, and Levine (2004) report positive effect of surface mail pre-notices and reminders. In this study reminders could not have been sent to potential respondents and the advertising had to rely on the Associations' regular way of contacting their members. As e-Bulletins and newsletters require additional subscription, some (or possibly most) of the arts therapists do not receive them and thus had less chance to get to know about the research. Therefore, the fact that music therapists were underrepresented in the sample could originate from a relatively uncontrollable recruitment procedure rather than from those therapists' lower willingness to take part. It could be that the professional online networking and marketing channels were simply more effective in the environments of art, drama and dance movement therapists. While the reached audience in not known, the response rate cannot be assessed making it difficult to comment on the effectiveness of the online survey in comparison to the paper-based distribution (as in Karkou, 1998).

Should this survey be replicated, it would be valuable to receive additional information from the Associations, which could help establish the numbers of therapists they could reach and the ratio of these numbers to the total population of arts therapists in the UK (e.g. number of therapists on records, who subscribe to newsletters or who receive e-bulletins). In addition, should the research budget be more substantial, adverts could be placed in professional journals, potentially reaching a wider audience.

The survey did not ask respondents about their ethnical background and it is recommended that such data are collected in any subsequent surveys.

Discussion

The proportions of arts therapists of different disciplines within groups indicate that drama and art therapists were more likely to

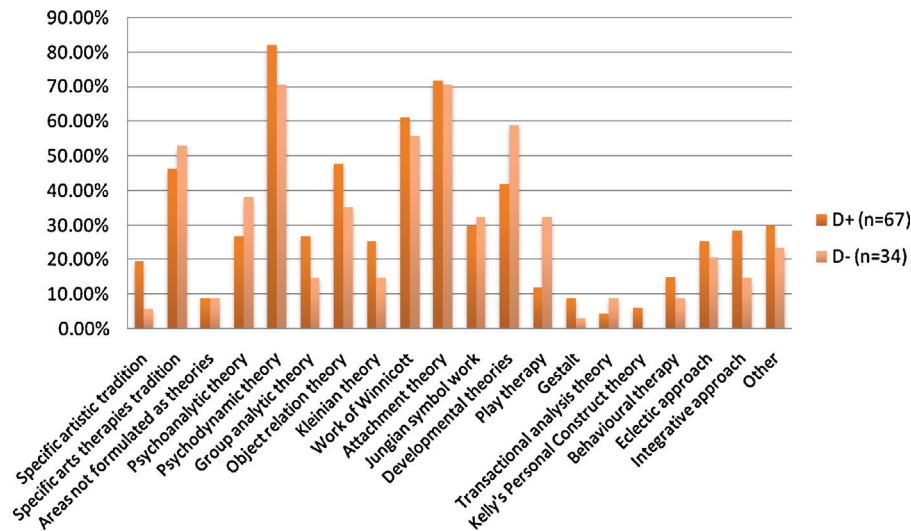


Fig. 6. Theoretical influences in two groups of arts therapists (D+ and D-).

work with depression than music and dance movement therapists. No other studies or data which could relate to this finding is known to the researchers.

Findings also seem to indicate that working with depression generally requires more experience from the therapists. Such result may as well be dictated by the notion that experience (and therefore time) is generally needed for a clinician to specialise in certain condition or approach. However, the last interpretation would need to be rejected, since therapists from group D± were more similar to group D+ in terms of age and experience. It seems therefore significant that among participating therapists, who did not encounter depression in their practice, 50% were relatively inexperienced. It may be that this results from the difficulties with the diagnosis of depression, e.g. less experienced therapists may miss depression; or it may be that younger and less experienced therapists are more likely to ignore co-morbidities and attribute certain dominant condition, other than depression, to their clients. Would older and more experienced therapists be more prone to look at their clients holistically and therefore detect depression more often, even when other problems appear more superficially salient? No studies which would explain the raised questions are known to the authors and this interesting and complex subject, which is not in the scope of this project, could well be explored in a separate research.

Also, interestingly, arts therapists in groups D+ and D± were most (and equally) likely to work in a health service, while therapists in group D- worked mostly in educational setting or private practice. Therefore, arts therapists' practice with depression seems to be often required within health services while it is very rarely present in educational settings. The two analysed criteria (main working environment and the age range of clients) suggest that tackling depression is a very common theme in arts therapists' work with adult clients, while it appears much less often in the work with children or adolescents. This may be an implication of a fact that prevalence of depression is highest among adults aged 25–64 (CDC, 2012; Rait et al., 2009). Alternatively, it may indicate that in the work with children and adolescents other themes are likely to dominate, with depression presumably 'hidden' or covert in some cases. The possible reasons for this finding may be explored further in future research.

Although individual therapy (as a therapy mode) was offered most often by arts therapists from all groups, the therapists who did not work with depression were more likely to work on one-to-one basis, while group work was much more common when depression was being addressed. Such result indicates that arts

therapists who specialised in working with depression especially valued the benefits of group work for their clients. Group work, therefore, seems to have additional benefits for depression specifically. While in other psychotherapies studies no differences were found between the effectiveness of group and individual therapy (Hodgkinson, Evans, O'Donnell, & Walsh, 1999; McDermut, Miller, & Brown, 2001), some highlight that evidence of effectiveness of group therapies not based on CBP is particularly limited (Huntley, Araya, & Salisbury, 2012). Comparison of group and individual arts therapies for depression may be worth considering in future research.

Arts therapists who encountered depression among their clients, tended to consider their clients' condition to be severe quite often and rarely evaluated it as mild. It is important to acknowledge that these were subjective judgements made by arts therapists, not necessarily confirmed by clinical diagnoses. The perception of severity of depression may differ quite significantly among various groups of professionals according to separate criteria, based on, for example, behaviour, social functioning, psychological condition or combination of these factors in various proportions. There may be several reasons for the more severe depression estimated more often by group D+ than D±, which this project cannot explore further. It seems natural that therapists who considered themselves specialists in working with depression would choose to work with more severe cases, for which their experience was suitable. However, it may also be true that those who work mainly with depression are highly sensitive towards its symptoms, which they tend to notice more often, while other therapists may remain relatively unaware of them. These and other reasons could be explored further in future research.

Conclusion

The group of arts therapists who took part in the study ($n = 395$) is a representative sample of the population of the art, drama and dance movement therapists in the UK, while it is not necessarily representative of the music therapists. The responses confirm that depression is a largely common condition, present in the clients of over 91% of therapists, who took part. Only small group of therapists reported that they did not encounter depression in their practice. While co-morbidity of depression with other conditions is high (Hammen & Watkins, 2007; Taylor & Fink, 2006), it does not usually present itself as a dominant disorder and often appears in the practice of therapists who do not consider themselves

specialists in depression. However, for some respondents this condition is the main area of professional interest and clinical experience. These therapists' answers helped to shape, with certain limitations, the picture of current arts therapists' practice with depression in the UK.

The quantitative analysis revealed that the therapists in the three identified groups differed significantly on a number of factors, including experience, age, main working environment, clients' age group, theoretical backgrounds and style of working. While common theoretical influences were generally indicated by the therapists in groups D+ and D–, analysis of factors identified by Karkou (1998) revealed stronger agreement of group D+ with Psychoanalytic principles. Arts therapists who worked primarily with depression also tended to be older and more experienced and work mainly with adults and rarely with children or adolescents. They most often provided individual therapy but tended to work with groups significantly more often than arts therapists who did not encounter depression among their clients.

Further research in the area would be advantageous and qualitative data could provide added depth to the quantitative findings presented here. It should be noted that specific parts of the presented Survey allowed for more in-depth qualitative analysis, which will be presented elsewhere. Also, interviews with arts therapists specialising in working with depression would strengthen the understanding and remain a recommendation for future research projects. While this study involved arts therapists practising in the UK only, it is possible that similar projects in other parts of Europe would reveal different or additional findings, as has already been observed in other comparative studies of arts therapies practice (Karkou, Martinsone, Nazarova, & Vaverniece, 2011), and they may therefore be recommended for a more universal understanding of the field.

References

- Blatt, J. (1996). Dance movement therapy. In C. Cordess, & M. Cox (Eds.), *Forensic psychotherapy: Crime, psychodynamics and the offender patient*. Vol. 2. Mainly practice. Forensic focus series. No. 1 (pp. 567–569). London: Jessica Kingsley Publishers.
- Cattanach, A. (1999). *Process in the arts therapies*. London: Jessica Kingsley Publishers.
- Centers for Disease Control and Prevention. (2012). *Current depression among adults*. Retrieved from <http://www.cdc.gov/Features/dsDepression/>
- Cook, C., Heath, F., & Thompson, R. L. (2000). A meta-analysis of response rates in web- or internet-based surveys. *Educational and Psychological Measurement*, 60(6), 821–836.
- Dokter, D. (1996). Being together briefly: One-on-one brief dramatherapy with clients hospitalized for chronic or reactive depression. In A. Gersie (Ed.), *Dramatic approaches to brief therapy* (pp. 188–200). London: Jessica Kingsley Publishers.
- Eminah, R. (1994). *Acting for real: Drama therapy process, technique, and performance*. New York: Brunner-Routledge.
- Evans, D. (2003). Hierarchy of evidence: A framework for ranking evidence evaluating healthcare interventions. *Journal of Clinical Nursing*, 12(1), 77–84.
- Hammen, C., & Watkins, E. (2007). *Depression* (2nd ed.). Hove, UK: Psychology Press.
- Health & Care Professions Council. (2011). *Registration statistics*. Available from <http://www.hpc-uk.org/publications/foi/index.asp?id=625>
- Hodgkinson, B., Evans, D., O'Donnell, A., & Walsh, K. (1999). *Comparing the effectiveness of individual therapy and group therapy in the treatment of depression (a systematic review)*. York, UK: Joanna Briggs Institute for Evidence Based Nursing and Midwifery.
- Huntley, A. L., Araya, R., & Salisbury, C. (2012). Group psychological therapies for depression in the community: Systematic review and meta-analysis. *The British Journal of Psychiatry*, 200(3), 184–190.
- IBM. (2012). SPSS software. Available from <http://www-01.ibm.com/software/uk/analytics/spss/>
- Kaplowitz, M. D., Hadlock, T. D., & Levine, R. (2004). A comparison of Web and mail survey response rates. *Public Opinion Quarterly*, 68(1), 94–101.
- Karkou, V. (1998). *Arts therapies practice in the UK*. Manchester, UK: University of Manchester (unpublished PhD thesis).
- Karkou, V., Martinsone, K., Nazarova, N., & Vaverniece, I. (2011). Art therapy in the postmodern world: Findings from a comparative study across the UK, Russia and Latvia. *The Arts in Psychotherapy*, 38(2), 86–95.
- Karkou, V., & Sanderson, P. (2006). *Arts therapies: A research-based map of the field*. Edinburgh, UK: Elsevier, Churchill Livingstone.
- Liebmann, M. (2007). *Art Therapy for Groups. A handbook of themes and exercises*. Hove, UK: Routledge.
- Maratos, A. S., Gold, C., Wang, X., & Crawford, M. J. (2008). Music therapy for depression. *Cochrane Database of Systematic Reviews*, 23(1). CD004517.
- McDermut, W., Miller, I. W., & Brown, R. A. (2001). The efficacy of group psychotherapy for depression: A meta-analysis and review of the empirical research. *Clinical Psychology: Science and Practice*, 8(1), 98–116.
- Meekums, B., Karkou, V., & Nelson, E. A. (2012). Dance movement therapy for depression. *Cochrane Database of Systematic Reviews*, 6 <http://dx.doi.org/10.1002/14651858.CD009895>
- National Institute for Health and Clinical Excellence. (2009a). *Costing statement: 'Depression' and 'Depression in adults with a chronic physical health problem'*. Retrieved from <http://www.nice.org.uk/nicemedia/live/12329/45943/45943.pdf>
- National Institute for Health and Clinical Excellence. (2009b). *Depression. The treatment and management of depression in adults*. In NICE clinical guideline 90. Manchester, UK: National Collaborating Centre for Mental Health. Retrieved from <http://www.nice.org.uk/nicemedia/live/12329/45888/45888.pdf>
- Odell, H. (1988). A music therapy approach in mental health. *Psychology of Music*, 16(1), 52–61.
- Payne, H. (1996). *One river many currents: Handbook of inquiry in the arts therapies*. London: Jessica Kingsley Publishers.
- Rait, G., Walters, K., Griffin, M., Buszewicz, M., Petersen, I., & Nazareth, I. (2009). Recent trends in the incidence of recorded depression in primary care. *The British Journal of Psychiatry*, 195, 520–524.
- Reynolds, F., Lim, K., & Prior, S. (2008). Narratives of therapeutic art-making in the context of marital breakdown: Older women reflect on a significant mid-life experience. *Counselling Psychology Quarterly*, 21(3), 203–214.
- Scott, J., & Dickey, B. (2003). Global burden of depression: The intersection of culture and medicine. *The British Journal of Psychiatry*, 183, 92–94.
- Scottish Intercollegiate Guidelines Network 114. (2010). *Non-pharmaceutical management of depression in adults. A national clinical guideline*. Edinburgh, UK: NHS Quality Improvement Scotland. Retrieved from <http://www.sign.ac.uk/pdf/sign114.pdf>
- Taylor, M. A., & Fink, M. (2006). *Melancholia: The diagnosis, pathophysiology and treatment of depressive illness* (1st ed.). Cambridge, UK: Cambridge University Press.
- World Health Organization. (2012). *Depression. A global public health concern*. Retrieved from http://www.who.int/mental_health/management/depression/who_paper_depression_wfmh_2012.pdf

Dance movement psychotherapy practice in the UK: Findings from the Arts Therapies Survey 2011

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Arts therapies practice in the UK, due to its complexity, is rarely adequately described and what constitutes main features of the professions often remains unclear. A nationwide Arts Therapies Survey was conducted in 2011 with the aim to offer a description of clinical practice with particular emphasis on work with depression. The survey received responses from 395 arts therapists, among whom 36 were dance movement therapists. While complete data from the survey is available elsewhere, this paper presents results particularly relevant to dance movement practitioners and highlights key areas of their practice, including usual work settings, client groups and preferred theoretical approaches. Both quantitative and qualitative data are used to illustrate the points discussed. Additionally, dance movement psychotherapists' responses concerning their work with depression are presented against other arts therapies professions' practice with this condition in the UK. Finally, areas for further research are recommended.

Keywords: dance movement psychotherapy; arts therapies; survey; clinical practice; depression

Introduction

Dance movement psychotherapy is a relatively young, but fast growing profession in the UK that is currently regulated by the Association for Dance Movement Psychotherapy UK (ADMP UK). Alongside art, music and dramatherapy, it is often associated with the wider field of arts therapies and is being considered a form of psychotherapy.

It has therefore been argued that the practice of dance movement psychotherapy (further referred to as 'DMP') draws upon a combination of psychotherapeutic and artistic traditions (Karkou & Sanderson, 2006). Although it is often suggested that dance movement therapists work with various client populations, in diverse settings and using a range of therapeutic tools (Payne, 2006), clear understanding of the main trends in DMP practice remains limited.

On the whole, research literature up to date has provided fairly fragmented descriptions of certain aspects of practice. By far, the most comprehensive map of the arts therapies field has been offered by Karkou and Sanderson (2006), who

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elaborate on DMP practice drawing upon a nationwide survey undertaken in 1996 (Karkou, 1998). The authors describe therapeutic principles commonly followed by practitioners and place DMP in the context of other arts therapies. Another core position in British literature offers a creative approach to DMP practice and helps situate the discipline within the broad field of psychotherapy (Meekums, 2002). Both texts define DMP in the UK context, allowing for an understanding of what the discipline involves and offering some clarification on its origins and therapeutic principles. Selected applications of DMP practice in the UK have been presented elsewhere (Payne, 1992, 2006) and case studies offer valuable insights into what actually happens in the therapy room. Despite the presence of these valuable and especially relevant in the UK context texts, the scope of DMP literature is still fairly narrow and lacks multiple perspectives. Therefore, there is a recognised need for more research in the field and more studies that identify core aspects of DMP practice as well as peculiarities and innovation.

The current report aims to add to the understanding on how, where and with whom dance movement therapists in the UK work.

Aims of the study and the current paper

This study for which the survey was conducted aimed to describe how arts therapists of all disciplines recognised in the UK work with depression. Some of the results from this project have been presented elsewhere (Zubala, MacIntyre, Gleeson, & Karkou, 2013) and will be followed by further reports, while the current paper utilises data collected in the survey to offer a description of characteristics of DMP practice in particular. More specifically, attempts to offer answers to the following questions are made:

- Who are dance movement psychotherapists in the UK?
- Where and with whom do they work?
- What theoretical backgrounds, evaluation methods and therapeutic principles determine their practice?
- What unique features distinguish DMP practice from other arts therapies disciplines?

With regard to researcher's specific interest in depression, additional question is raised:

- Do dance movement psychotherapists in the UK work with depression? What is the extent of this work?

Methodology

In order to answer the above questions, an online Arts Therapies Survey was launched in June 2011 and closed in September 2011. There were 395 responses to this survey coming from arts therapists of all four disciplines recognised in the UK, offering insights into various aspects of clinical practice, including theoretical approaches, therapeutic principles, aims, methodology and evaluation.

The questionnaire used in the survey was developed by Karkou in 1996 (Karkou & Sanderson, 2006) and consisted of multiple choice, single choice and open-ended items. They concerned the following areas of arts therapies practice: information

about work settings and client groups (eight items), theoretical influences (two items), evaluation and assessment (four items) and biographical information of therapists (six items). Another 34 questions concerned therapeutic principles that required respondents to indicate their level of agreement to provided statements on a scale of 1 to 5. These statements were grouped into six factors through prior factor analysis and were labelled: humanistic, psychoanalytic/psychodynamic, developmental, artistic/creative, active/directive and eclectic/integrative. Each of the six factors presented acceptable internal consistency (α ranging from 0.56 to 0.71) and were seen as capturing some of the complex aspects of arts therapists' practice in the UK (Karkou & Sanderson, 2006) and across Europe (Karkou, Martinson, Nazarova, & Vavermiece, 2011).

For the purpose of the particular research on depression, the survey was adapted in 2011 to include three additional items, enabling identification of arts therapists who work specifically with the condition. An online version of the questionnaire was developed using the Bristol Online Surveys system (www.survey.bris.ac.uk). The New mode of delivery and slight changes to the original survey called for an assessment of its suitability and quality, and the survey was initially evaluated in a pilot among arts therapists at Queen Margaret University. The participants of the pilot ($n=29$) evidently accepted the online mode of delivery, agreed that the questions were easily understandable and their meanings were clear, and positively commented on the survey's structure, content and presentation. They also offered additional feedback on the valuable opportunity to take time to focus directly on a comprehensive review of their clinical practice.

Participants

The study focused on responses from arts therapists who were qualified to practise within the UK, having completed relevant training at a postgraduate level and/or having acquired licence to practise from one of the relevant regulating bodies for arts therapies. Every attempt was made to reach as many as possible of around 3000 arts therapists registered in the UK at the time (in 2010, according to Health Professions Council's [now Health & Care Professions Council, HCPC] statistics).

An invitation to take part in the survey was distributed among arts therapists in the UK with the help of Arts Therapies Professional Associations (British Association of Art Therapists, ADMP UK, British Association for Music Therapy and The British Association of Dramatherapists). The associations agreed to include advertising material in their newsletters, e-Bulletins and members' areas on the websites. Relevant networking groups, clinical and educational settings were also informed about the study. Advertising through professional associations and other respected and trusted professional groups ensured that only qualified and registered practitioners had been invited to take part.

Results

The survey received 395 responses in total, coming from therapists of four arts therapies disciplines. Dance movement psychotherapists formed the smallest group ($n=36$, 9.1% of the total sample), outnumbered by music therapists ($n=50$),

dramatherapists ($n=59$) and art psychotherapists ($n=243$). The relatively small number of dance movement psychotherapists participating in this study actually represents well the proportion of these professionals in the total population of arts therapists in the UK. Data available from the HCPC (2011) and ADMP UK suggest that dance movement psychotherapists form the smallest group among arts therapies professions (around 6.5% of all arts therapists – estimate based on approximately 212 practitioners registered with the ADMP UK in 2011).

Further report is based on data collected from the 36 respondents of DMP profession, further referred to as 'DMP group' or simply 'respondents'. Whenever relevant, results are occasionally related to the total sample or other arts therapies disciplines (further referred to as 'group AT + MT + DT' where AT indicates art therapists, MT indicates music therapists and DT indicates dramatherapists).

Quantitative data analysis was conducted using SPSS19 software for descriptive and inferential statistics (IBM, 2012). Due to small number of responses given by dance movement therapists to open-ended questions, a systematic qualitative analysis was not performed. However, therapists' comments often illustrate and complement quantitative results and are therefore included in the report. When direct quotations are used, they are labelled with respondent number only (e.g. R3).

Biographical information

The total sample ($n=395$) consisted of 84% female and 16% male respondents. In the DMP group ($n=36$), females constituted 92% and males 8%. It is estimated (HCPC, 2011) that the percentage of female and male therapists in the total population of arts therapists corresponds to the proportions in the total sample of this study. Since dance movement therapists were not part of the HCPC in 2011 and were not accounted for in these statistics, it remains unknown whether the proportions of females and males in the DMP group is representative for the general population. However, in the generally female-dominated professions of arts therapists, a similar or possibly even stronger predominance of females among dance movement psychotherapists may be assumed.

The DMP group consisted of respondents on a wide age spectrum. Age under 41 years was declared by 53% of therapists, while the remaining 47% were over 41. Moreover, 25% of respondents were aged 30 or under, and only 17% were aged 51 or over. Interestingly, among respondents of other arts therapies disciplines (group AT + MT + DT), less than 7% were under the age of 31 and 43% were aged 51 or over. The differences between groups DMP and AT + MT + DT are statistically significant with regard to the youngest and the most mature therapists (see Table 1). Results seem to therefore suggest that there were younger practitioners among dance movement therapists than in other arts therapies disciplines. Group AT + MT + DT appeared to include significantly more mature practitioners.

Exactly 50% of respondents from the DMP group reported to have had 7 or less years of experience, while nearly 14% practised for over 15 years. Significantly longer experience was reported by many therapists of other arts therapies disciplines (see Table 1). In this group, over 35% of respondents had more than 15 years of experience and just under 20% worked for less than 3 years (as compared to nearly 42% in the DMP group).

Table 1. Biographical information of arts therapists in DMP group compared to other arts therapists: AT + MT + DT.

Biographical information of arts therapists	DMP (%)	AT + MT + DT (%)	z-value
Sex			
F	91.7	83.3	
M	8.3	16.7	
Age			
<30	25.0*	6.7*	2.5
31–40	27.8	22.3	
41–50	30.6	28.4	
51–60	13.9**	31.5**	2.8
>60	2.8*	11.1*	2.6
Years of experience			
<3	41.7*	19.8*	2.5
4–7	8.3	16.2	
8–11	19.4	17.0	
12–15	16.7	11.7	
>15	13.9**	35.4**	3.4

Note: Highlighted areas of statistically significant difference: *at 95% confidence interval; **at 99% confidence interval, based on z-test.

Style of working (work setting, group vs individual work, work alone vs in a team)

Therapists in the DMP group stated that they worked on their own as well as in teams with other professionals and other arts therapists nearly equally often (see Table 2). All three styles of working were reported by between 47.2% and 50.0% respondents and were similarly common among respondents of other arts therapies disciplines (proportions were not statistically different). Therapists who chose the option 'Other' commented that they worked in combination of the above and one respondent highlighted the potential loneliness of a dance movement therapist in

Table 2. Style of working of therapists in the DMP group compared to respondents in group AT + MT + DT.

Arts therapists' style of working	DMP (%)	AT + MT + DT (%)	z-value
Lone and/or team work			
On my own	50.0	57.7	
Team – with other arts therapists	47.2	30.1	
Team – with other professionals	47.2	59.6	
Other	13.9	5.8	
Working environments			
Health service	38.9**	60.4**	2.9
Educational setting	27.8	27.0	
Private practice	33.3	30.1	
Voluntary agency	13.9	18.4	
Social service	19.4	12.5	
Other	19.4	11.4	
One-to-one or group work			
One-to-one	61.1**	85.5**	2.9
Families/couples/dyads	11.1*	24.0*	2.2
Groups	88.9**	65.5**	4.0

Note: Highlighted areas of statistically significant difference: *at 95% confidence interval, **at 99% confidence interval based on z-test.

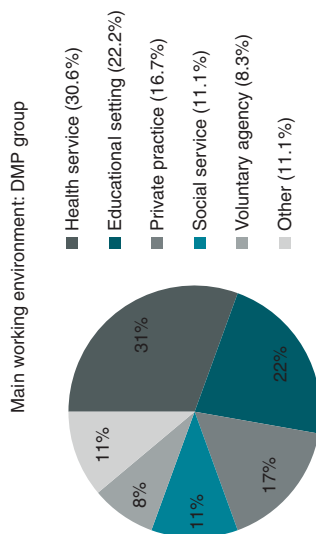


Figure 1. Main working environment, as reported by therapists in DMP group.

a clinical setting: 'Work across 2 NHS Trusts, one does not have other Arts Therapists' (R6).

Asked to select all environments, in which they see their clients, therapists in DMP group chose 'health service' most often (38.9%), followed by 'private practice' (33.3%) and 'educational setting' (27.8%). Work in voluntary agencies and social services proved less common. Although health service was indicated most often by DMP practitioners, it was even more often selected by therapists of other disciplines (group AT + MT + DT), of whom 60.4% reported that they worked in this particular environment. The difference between the two groups of therapists is statistically significant with regard to health service setting, while other working environments were indicated equally often by both groups (see Table 2). When prompted to identify only one setting as a main working environment (see Figure 1), therapists in the DMP group similarly referred to the 'health service' most often (30.6%). Among settings not listed but mentioned by the respondents were residential/care homes and charity organisations (the latter understood by the authors to belong to the 'voluntary agency' category).

Therapists in the DMP group reported that they worked with groups most often (88.9%), but practice with individual clients was also common (61.1%), while work with families and couples was reported less often (11.1%). In comparison, practitioners of other arts therapies disciplines appeared to offer one-to-one therapy most often (85.5%), followed by group work (65.5%) and, the least common, work with families/couples (24%). Differences between the two groups of therapists were statistically significant in all types of therapy offered (see Table 2). Respondents from the DMP group worked significantly more often with groups and less often with individuals and families/couples than respondents from other arts therapies disciplines.

Client groups (age group and type of difficulty)

While the data suggest that dance movement psychotherapists worked with clients from all age groups (see Figure 2), practice with adults aged 16–65 was most common (reported by nearly 70% of therapists in the DMP group), followed by work with young adults aged 17–25 (just over 47%). One-third of respondents worked

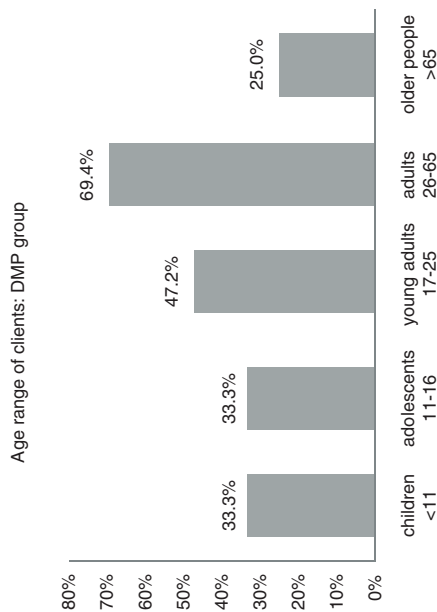


Figure 2. Age range of clients of therapists in the DMP group.

with children or adolescents, while practice with older people (aged over 65) was the least common (reported by 25% of respondents). These figures did not differ statistically for therapists of other arts therapies disciplines and practice with adult population seemed most common across the professions.

Asked to identify dominant difficulties within the main client group, 50% of dance movement therapists indicated mental health problems (see Figure 3). Learning difficulties were the next popular choice (22.5% of therapists), multiple problems were indicated by 8.3% of therapists and other difficulties received little response. Among other main client difficulties, suggested by respondents and not listed in the questionnaire, were dementia (5.6%) and difficulties on autistic spectrum disorder (2.8%). Similarly to the age of clients, their main difficulties appeared not to differentiate between the DMP and AT + MT + DT groups. For all

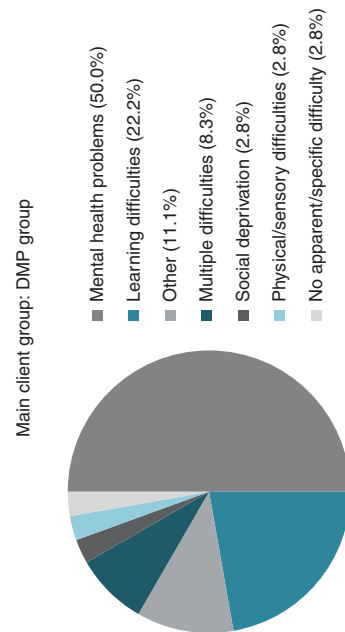


Figure 3. Main client groups, as reported by arts therapists in DMP group.

arts therapies professions, mental health problems remained the main client presentation and, with slight although not statistically significant differences, other predominant client conditions were equally common across the disciplines.

Theoretical influences

In one of the questionnaire items, therapists were asked to indicate their theoretical influences. Nearly 70% of respondents in the DMP group referred to psychodynamic theory (see Figure 4); developmental and attachment theories were also popular (indicated by just over 61%) and were followed by the work of Winnicott (50%), specific arts therapies traditions (44.4%) and integrative approaches (41.7%). Behavioural therapy and Kelly's personal construct theory were the least popular influences.

In order to examine whether the reported theoretical influences were common among arts therapies practitioners in general, of whether specific theories had an impact

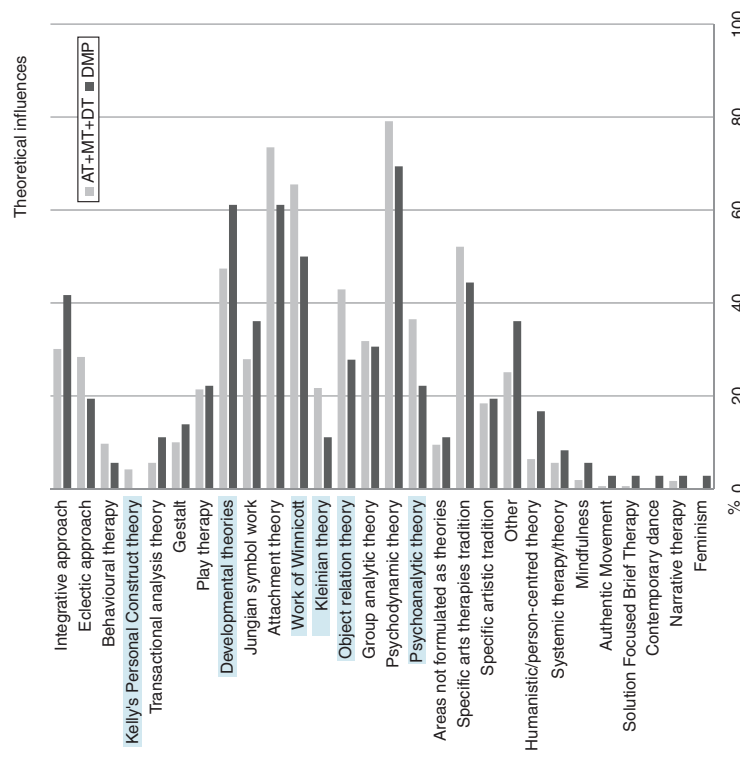


Figure 4. Theoretical influences in two groups of arts therapists. Note: Highlighted areas of statistically significant difference, last seven influences listed by therapists who chose option 'other'.

on DMP practice in particular, the DMP group was compared to the group consisting of other arts therapists (AT + MT + DT). While data appeared to indicate similarities in both groups, with the strongest influence reported in psychodynamic theory, statistical analysis was performed to determine any significant differences. Analysis of proportions revealed that dance movement therapists were significantly more often influenced by developmental theories than other arts therapists ($z = 2.2$ at 95% confidence interval). Conversely, group AT + MT + DT was more prone to be influenced by psychoanalytic, object relations and Kleinian theories as well as the work of Winnicott (z between 1.8 and 1.9 at 90% confidence interval) and Kelly's personal construct theory ($z = 4.0$ at 99% confidence interval).

In additional comments, dance movement therapists also shared other theories, not listed in the questionnaire, that they considered inspirational. Some of these additional influences were mentioned by more than one respondent and therefore it seemed important to include them in the analysis. Of these self-reported influences, humanistic/person-centred approaches were mentioned most often (16.7% of respondents). For comparison, occurrences of similar theories were sought in responses of therapists of other disciplines (AT + MT + DT) and were included in Figure 4.

Assessment and evaluation of practice

Certain items of the questionnaire addressed the areas of practice related to: (i) assessment of client suitability for therapy on offer and (ii) the determinants on which therapists evaluate their practice.

Figure 5 gathers dance movement therapists' responses to the listed criteria for assessing clients' suitability for treatment. The most popular methods of assessment, chosen by 75% of therapists, included: a feeling that 'we can work together', client's struggle to find words for his/her feelings and client's communication problems. A need for emotional outlet was also considered a popular criterion (nearly 70% respondents – see Figure 5). Some therapists chose to suggest other criteria and the ones mentioned by at least two respondents included: referral from the team/treatment plan and an inclusive belief that all clients are suitable: 'all clients are suitable in my fields of work as it is what we all do – move' (R24), 'anyone can benefit from art therapies, just in different ways' (R28).

Figure 6 gathers indicators that help practitioners evaluate their therapeutic work with clients. Some of the evaluation methods were particularly popular among dance movement therapists. Changes in behaviour were mentioned most often (nearly 89% of therapists in the DMP group), followed by verbal/non-verbal communication (86.1%), engagement with therapy process (83.3%) and emerged themes (80.6%). Among other indicators enabling evaluation, the respondents mentioned increased flexibility (both psychological and physical), reduction of distress and individual or group shifts/changes, including physical and cognitive aspects. One of the respondents highlighted that 'evaluation is collaborative and on-going' (R6) in her/his practice, possibly referring to work within multidisciplinary teams.

Therapeutic principles

Dance movement psychotherapists' preference for specific therapeutic approaches (six factors identified by Karkou in 1998) was measured and the results in the DMP

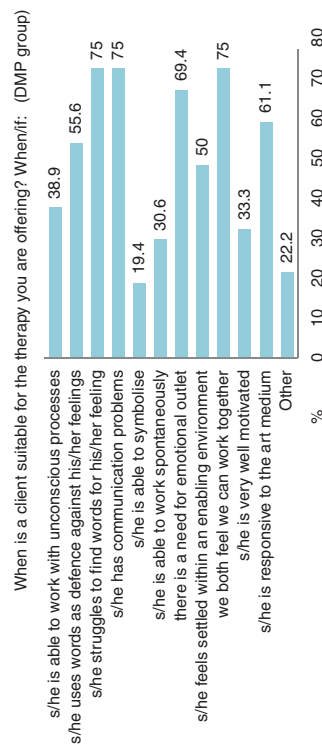


Figure 5. DMP therapists' responses indicating client suitability for the therapy they offer.

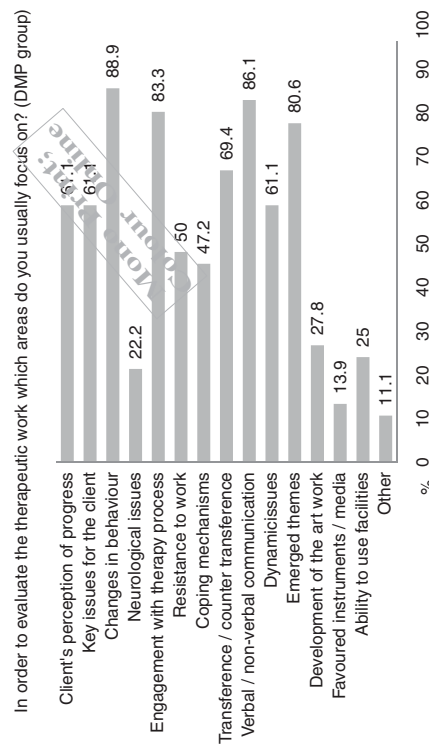


Figure 6. DMP therapists' responses indicating determinants for evaluation of the therapeutic work.

group were then compared to the AT + MT + DT group to determine whether arts therapists of different disciplines differ in their chosen approach. Table 3 lists therapeutic principles in order of preference for the DMP group; humanistic principles were the most popular, followed by integrative/eclectic approach. (Note that lower means indicate higher level of agreement, on a five-point scale, where 1 = strongly agree and 5 = strongly disagree.) Active/directive approach was the least common among dance movement therapists.

An independent samples t -test revealed statistically significant differences between the DMP and the AT + MT + DT groups in preferred therapeutic principles. Dance movement therapists agreed with humanistic principles more strongly than other arts therapists ($t = -3.8$, $df = 392$, $p < 0.05$). Moreover, although active/directive approach was the least preferred among dance movement

Table 3. Comparison of two groups of arts therapists (DMP and AT + MT + DT) in relation to the six factors – in order of preference for DMP group.

Therapeutic principles	Discipline	N	Mean	SD	Std. error mean
Humanistic	DMP	36	1.8254*	0.49500	0.08250
	AT + MT + DT	358	2.1899*	0.55391	0.02927
Eclectic/integrative	DMP	36	2.1083	0.71768	0.11961
	AT + MT + DT	356	2.1695	0.60049	0.03183
Psychoanalytic/psychodynamic	DMP	36	2.3778	0.68591	0.11432
	AT + MT + DT	356	2.2600	0.58503	0.03101
Artistic/creative	DMP	36	2.4583	0.55259	0.09210
	AT + MT + DT	358	2.5162	0.55491	0.02933
Developmental	DMP	36	2.5000	0.69857	0.11643
	AT + MT + DT	353	2.3763	0.66312	0.03529
Active/directive	DMP	36	2.5444*	0.73073	0.12179
	AT + MT + DT	353	2.7893*	0.55202	0.02938

*Significant difference indicated by *t*-test, $p < 0.05$.

therapists, it was still more popular among these practitioners than among arts therapists of other disciplines ($t = -2.45$, $df = 387$, $p < 0.05$).

Apart from quantifiable items, one of the open-ended questions asked therapists to comment freely on any aspect of their therapeutic practice. Some respondents used this opportunity to share what in their opinion constitutes the essence of the therapeutic process or how different theoretical approaches were used to best respond to clients' needs. In the comment below, possible benefits of DMP were highlighted and core areas for potential improvements through therapy were being revealed:

I work a lot on encouraging integration, empowerment, communication, individuals making choices, developing social skills, being part of a process, exploring their own creativity. Working towards reaching ones full potential – drawing on individuals abilities. Exploring safe ways to express feelings and emotions. (R15)

It is apparent that the respondents expressed their willingness to adapt their approaches according to client population they work with. The flexibility in practice extends to theoretical backgrounds, with certain approaches more suitable to particular client groups. One respondent described how she/he worked with clients suffering from dementia and explained the core focus of this type of intervention:

When I worked with adopted and fostered children, I referred a lot to attachment theory (...) With people affected by dementia I take a very different, more person-centred approach, and (...) the therapy work is much less about process and more about being in the moment and enabling expression and communication [and about] helping people to live as well and as fully as possible at whatever point they are. (R34)

Work with depression

In addition to the characteristics presented above, the survey collected data on arts therapists' practice with depression in particular. Specific items in the questionnaire allowed for identification of those therapists who worked primarily with depression, those who encountered depression among their clients and those who did not work with the condition at all.

Figure 7 illustrates the commonness of client depression among DMP practitioners. Over 80% of respondents encountered depression in their practice; among them there were therapists who specialised in working with the condition (8.3% of the DMP group). A relatively low percentage of therapists did not encounter depression in their practice (19.4%).

While the results appear to suggest that depression was a common condition among clients of DMP practitioners, it seems that working with the condition was even more frequently undertaken by other arts therapists (group AT + MT + DT). A total of 17.8% of the latter group specialised in working with depression and only 7.5% reported not to have depression among their clients. The differences in the frequency of working with depression between the DMP and the AT + MT + DT group are statistically significant (with $z = 1.9$ and 1.7 , respectively, at 90% confidence interval).

Although a thorough qualitative analysis may not have been undertaken due to the small number of responses to open-ended questions, comments from DMP practitioners on their work with depression revealed the complexity of the condition and highlighted its co-morbidity with other mental health issues. Two of the respondents noticed the connection between depression and dementia: 'Dementia and depression often occur together, so many of my clients experience depression at some point in their illness' (R34). One therapist shared that 'in acute ward admissions many patients are depressed but it is unlikely that this is the reason for their admission' (R10) and commented on her/his practice with refugees among whom the condition is common. Another respondent noticed how depression among clients with learning disabilities might at times be attributed to purely behavioural presentation and further commented: 'I am ever mindful of the potential for this client group to become depressed or to be suffering from depression and I pay a lot of attention to my embodied somatic responses in relation to my clients' (R16). One dance movement therapist shared that 'the medium [dance/movement] can help to find antidote' for depression and that she/he approached the condition by allowing clients 'to express how they are, and be seen/heard' (R6).

Limitations

Although efforts were made to reach all therapists practising in the UK, the distribution of advertising through Arts Therapies Associations could only partially be controlled by the researcher and therefore it was not possible to assess the exact number of therapists,

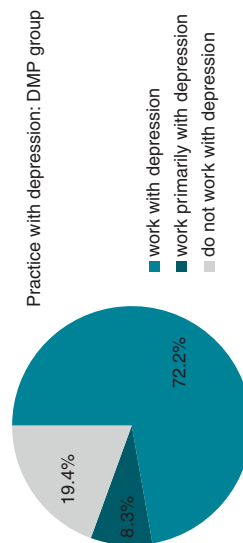


Figure 7. Practice with depression among therapists in the DMP group.

who received an invitation to take part in this study. This may possibly account for the relatively small number of respondents practising DMP. Should the survey be replicated, it would be valuable to receive more information from the Associations about the means they used to circulate relevant information and the total number of people their distribution lists consisted of. Additionally, adverts in relevant professional journals would potentially increase the number of respondents.

The current study described DMP practice in relation to other arts therapies disciplines. However, the professions of art, music and dramatherapists were considered one group for the purpose of this project and therefore the findings need to be interpreted as a comparison between the practice of dance movement psychotherapists and other arts therapists in general, rather than comparisons with separate professions.

While the current survey did not collect data on the cultural backgrounds of the therapists, such information would be especially valuable for any comparative international studies. Obtaining cultural data is thus recommended in any similar forthcoming surveys.

Discussion

Arts therapies are relatively new professions in the UK but the steadily growing number of therapists, an interest in training in the disciplines and progress in arts therapies research suggest that the field is rapidly developing. The findings of the current study, concerning dance movement psychotherapists, additionally seem to confirm that these practitioners represent a particularly young and fast growing discipline (Karkou & Sanderson, 2006) with a relatively young age of therapists and a fairly short average time in practice. While arts therapies are generally female-dominated disciplines, dance movement therapy seems to include an even larger proportion of female practitioners. Further research may possibly explore what leads to relatively young age of DMP practitioners. It is possible that the reason lies in the actual young age of the discipline or, alternatively, dance movement practitioners might tend to leave the profession after a certain age, similarly to dance professionals.

The environments in which dance movement therapists work include a wide range of settings and working arrangements. Practice alone and within teams seems equally common. Interestingly, even though registration of dance movement psychotherapists with the HCPC is still pending, health settings are the most popular working environment for these practitioners. It is possible that the finding that the health setting is an even more common working environment for other arts therapists is a reflection of the 'anomaly' in the professional registration of arts therapists in the UK. Other usual work settings include private practice and educational institutions. It is worth noting that the survey undertaken by Karkou in 1996 clearly identified education as a main working environment for dance movement therapists, while for other arts therapists health setting was the primary place of practice (Karkou, 1998). The current study, therefore, suggests that over the last 15 years there have been significant changes to the work settings of dance movement therapists, whose most commonly offered practice has by now moved from educational to health settings to resemble a general tendency in the whole field

of arts therapies. Since health settings still remain significantly less common working environments for dance movement therapists than for respondents of other arts therapies disciplines, a trend for DMP to be practised more often in health settings in the future may be predicted. However, for a sustainable expansion of arts therapies, and dance movement psychotherapy in particular, in the health sector, a number of conditions would need to be met. These may include: (1) growth of high quality research evidence, (2) further development of links between the NHS and the universities and support for trainee placements and (3) registration of the DMP profession with HCPC or possibly UKCP. Time may seem right for dance movement practitioners to negotiate their presence in the National Health System, despite economic difficulties, while increasing attention to the body through mindfulness programmes is evident. In light of the current situation in the NHS, the above is certainly a particularly interesting finding that would need to be further clarified through future studies, which may, for example, explore attitudes of the NHS and other agencies to employing DMPs and their understanding of what arts therapies may offer.

Although dance movement therapists work in all therapeutic configurations, including group, one-to-one and family therapy, practice with groups is most common in comparison to other arts therapies disciplines, in which individual therapy is offered most often. Even though the current study does not offer further clarification on this subject, it may be assumed that there is an existing tradition of dance movement therapy being facilitated in groups as a direct reference to how dance as a social and art form is commonly delivered, or that this is what is most often required in the settings where the therapists work. No other studies that could relate to this finding are known to authors and further research is recommended.

The fact that arts therapies in the UK are offered to diverse client populations has been explored by Karkou and Sanderson (2006) and is evident in the registers of practitioners from the different professional associations. Numerous informal accounts from the therapists and published literature confirm that the practice is relevant for people of different ages and experiencing a variety of difficulties (e.g. Payne, 2006). The current study identifies main client groups in DMP practice and suggests that certain client difficulties are equally common across arts therapies disciplines, with mental health problems being predominant.

Among the theories that influence DMP practice, humanistic, psychodynamic, developmental and attachment ideas seem the most popular. It is important to mention that the survey offered a direct opportunity to declare theoretical influences and additionally measured the actual behaviour through levels of agreement with the six therapeutic factors. The respondents were more likely to indicate psychodynamic principles when choosing from the ready-made list, but revealed stronger agreement with the humanistic principles measured through factors. It is possible that the training determines a more psychodynamic thinking among the therapists, but the actual practice follows more humanistic ethos. It might also be worth noting that humanistic theory was not directly mentioned in the given list and it may be assumed that, should they be listed, humanistic principles would have been chosen often and possibly more often than the currently leading psychodynamic theory.

Therefore, although all of the above mentioned approaches are influential in arts therapies in general, humanistic and developmental theories seem to have a particular impact on dance movement therapy practitioners. This finding is not different from findings from the survey of 1996 (Karkou, 1998; Karkou & Sanderson, 2006). Furthermore, when it came to overall therapeutic trends, the authors of the 1996 survey concluded that, in comparison to other arts therapists, DMP practitioners placed higher value in humanistic ideas, a feature of DMP practice that appears to remain the same 15 years later. Also, although an active/directive approach is not common among arts therapists in general, dance movement therapists are more likely to use active/directive interventions than other respondents. This, again, may reflect the nature of dance as a medium as well as existing training and practices. It is interesting that in the latest survey reported here, the active/directive nature of the work is statistically different from other arts therapies in the UK, in a way that was not apparent in the survey of 1996 (Karkou, 1998; Karkou & Sanderson, 2006). Finally, willingness to adapt own practice and to utilise various theoretical perspectives in order to best address client needs is apparent. A strong agreement among DMP practitioners with eclectic/integrative approaches has already been commented on by Karkou and Sanderson (2006) and appears to be suggested again in this more recent study.

The core criteria indicating client suitability for treatment offered by dance movement therapists included communication problems and difficulties with finding words for expressing feelings. The choice does not seem surprising given the nature of DMP practice, which offers clients an opportunity to communicate outwith verbal channels. This unique feature of arts therapies has been widely discussed against verbal psychotherapy approaches (Odell-Miller, Hughes, & Westacott, 2006; Thyme et al., 2007). Moreover, a mutual feeling that working together is possible seems a crucial criterion for client suitability for therapy, while spontaneity, motivation, ability to symbolise and work with unconscious processes seem less important. Similar findings were suggested by Karkou and Sanderson (2001) and the current survey confirmed the significance of certain suitability criteria in dance movement therapy.

Communication (both verbal and non-verbal) and behavioural changes were highlighted by dance movement therapists as the most popular means of therapy evaluation. Emergent themes often assist in assessment and engagement in therapy process has also been identified as crucial. Exactly the same areas of therapeutic work were considered most important in evaluation of practice in the previously undertaken survey (Karkou & Sanderson, 2001) and the current findings seem to confirm that evaluation routine is fairly established among dance movement therapists. It is important to note that the current findings do not mention of standardised outcome measures or systematic movement observation (e.g. Laban, 1975; Loman & Merman, 1996) in the evaluation of treatment. Since these may be expected in DMP practice, further research into evaluation of the therapeutic work, including more specific methods, is recommended.

The Previous study has shown that work with depression was relatively most common among art therapy and dramatherapy practitioners, while dance movement therapists most often stated that they do not encounter depression in their clinical practice (Zubala et al., 2013). However, it needs to be highlighted that, although less

common than in other arts therapies, depression is a hugely popular condition among clients of dance movement therapists and attempts to evaluate DMP for the condition have been made (Meekums, Karkou, & Nelson, 2012). In addition, the current study offered high quality comments on therapists' practice with dementia suggesting that knowledge and expertise in the condition seems to be particularly strong among dance movement therapists. A more thorough description of DMP with dementia would add to relatively modest in scope literature currently available (e.g. Coaten, 2009; Hill, 2009; Kovarzik, 2006).

Conclusion

This study reveals the wide scope and flexibility of dance movement therapy practice, which is undertaken in a variety of settings and utilising a range of therapeutic principles in a creative way in order to best address complex difficulties of diverse client populations. In relation to the general population of arts therapists, dance movement practitioners tend to work more often with groups, with clients presenting other than mental health difficulties and adopting approaches stemming primarily from humanistic and psychoanalytic/psychodynamic traditions in eclectic/integrative way.

While the current work offers a degree of understanding of the principles and other aspects of therapeutic work of DMP practitioners in the UK, further research in the area would be advantageous. Since dance movement therapy is a young and fast growing profession, a repetition of the survey in the future could likely provide a larger number of responses and explore the directions in which the DMP practice in the UK develops. Additionally, further comparative studies in other parts of Europe currently underway (Karkou et al., 2011) would potentially allow for a more universal understanding of the field.

The presented findings refer to the general principles of the therapeutic practice and, since only the work with depression was more thoroughly explored, it certainly remains recommended that future studies focus on more in-depth explorations of practice with specific client populations or within specific settings. Since mental health problems were identified as a main client presentation, what conditions in particular are common in dance movement therapy practice and how they are approached in therapy would be worth exploring. More qualitative data, gathered possibly through interviews with therapists, would strengthen the understanding and may potentially offer meaningful clinical guidance to the interested practitioners. Further high quality research on DMP practice with depression is highly recommended to complete already initiated work (Meekums et al., 2012; Zubala et al., 2013). Moreover, while certain ways of working with dementia have been highlighted by participants in this study, further research on this subject seems especially relevant.

On a final note, it is worth mentioning that once the current DMP practice is thoroughly understood and described, its effectiveness may then be meaningfully explored in research utilising rigorous randomised controlled trial designs. The need for such studies has to be acknowledged for different reasons. For one, they can directly contribute towards professional recognition. At the same time, studies of effectiveness with rigorous designs can make a potential contribution towards

clinical practice that draws upon research evidence and upon a comprehensive understanding of what may be effective (Ritter & Low, 1996). Mapping the field appears to be a first step in this direction. Once we are clear about what we are doing, we can start finding out which elements of our work are indeed useful for our clients and what may be worth changing.

References

- Cooten, R. (2009). *Building bridges of understanding: The use of embodied practices with older people with dementia and their care staff as mediated by dance movement psychotherapy* (Unpublished doctoral dissertation). Roehampton University. Retrieved from <http://hdl.handle.net/10142/96191>
- Health & Care Professions Council [HCPC]. (2011). Registration statistics. Retrieved from <http://www.hpc-uk.org/publications/foi/index.asp?id=625>
- Hill, H. (2009). Dancing with hope: Dance therapy with people with dementia. In S. Chaiklin & H. Wengrower (Eds.), *The art and science of dance/movement therapy* (1st ed., pp. 181–194). Hove: Routledge.
- IBM. (2012). SPSS software. Retrieved from <http://www-01.ibm.com/software/uk/analytics/spss/>
- Karkou, V. (1998). *Arts therapies practice in the UK* (Unpublished doctoral dissertation). University of Manchester.
- Karkou, V., Martinson, K., Nazarova, N., & Vaverniece, I. (2011). Art therapy in the postmodern world: Findings from a comparative study across the UK, Russia, and Latvia. *The Arts in Psychotherapy*, 38, 86–95.
- Karkou, V., & Sanderson, P. (2001). Report: Theories and assessment procedures used by dance/movement therapists in the UK. *The Arts in Psychotherapy*, 28, 197–204.
- Karkou, V., & Sanderson, P. (2006). *Arts therapies: A research-based map of the field*. Edinburgh: Elsevier, Churchill Livingstone.
- Kovarzik, U. (2006). Opening doors: Dance movement therapy with people with dementia. In H. Payne (Ed.), *Dance movement therapy: Theory, research and practice* (2nd ed., pp. 17–30). London: Routledge.
- Laban, R. (1975). *Laban's principles of dance and movement notation* (2nd ed.). London: MacDonald and Evans.
- Loman, S., & Merman, H. (1996). The KMP: A tool for dance/movement therapy. *American Journal of Dance Therapy*, 18, 29–52.
- Meekums, B. (2002). *Dance movement therapy: A creative psychotherapeutic approach* (1st ed.). London: Sage.
- Meekums, B., Karkou, V., & Nelson, E. A. (2012). Dance movement therapy for depression. *Cochrane Database of Systematic Reviews*, 6, CD009895. doi:10.1002/14651858.CD009895
- Odell-Miller, H., Hughes, P., & Westacott, M. (2006). An investigation into the effectiveness of the arts therapies for adults with continuing mental health problems. *Psychotherapy Research*, 16, 122–139.
- Payne, H. (1992). *Dance movement therapy: Theory and practice* (1st ed.). London: Routledge.
- Payne, H. (2006). *Dance movement therapy: Theory, research and practice* (2nd ed.). London: Routledge.
- Ritter, M., & Low, K. G. (1996). Effects of dance/movement therapy: A meta-analysis. *The Arts in Psychotherapy*, 23, 249–260.
- Thyme, K. E., Sundin, E. C., Stahlberg, G., Lindstrom, B., Eklof, H., & Wiberg, B. (2007). The outcome of short-term psychodynamic art therapy compared to short-term

psychodynamic verbal therapy for depressed women. *Psychoanalytic Psychotherapy*, 21, 250–264.

Zubala, A., MacIntyre, D. J., Gleeson, N., & Karkou, V. (2013). Description of arts therapies practice with adults suffering from depression in the UK: Quantitative results from the nationwide survey. *The Arts in Psychotherapy*, 40(5), 458–464. doi:10.1016/j.aip.2013.09.003